S. Hrg. 100-449

AIDS AND THE VETERANS' ADMINISTRATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 24, 1987

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
81-465 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

5761-6

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AIDS AND THE VETERANS' ADMINISTRATION

WEDNESDAY, JUNE 24, 1987

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:36 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston, DeConcini, Graham, Murkowski, Thurmond, and Stafford.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Good morning. The committee will come to order. The Chairman will be here in a few minutes.

I have another appointment, so I will have to go. So, I wanted to make a statement first. It is a pleasure to be here today to receive testimony on one of the most perplexing issues facing our country today—Acquired Immune Deficiency Syndrome. Mr. Chairman, this is an issue which requires our very careful and thoughtful attention, and I want to commend the Chairman for scheduling these hearings.

President Reagan has recently declared that AIDS is the No. 1 public health problem of this Nation. The facts bear this out. Over 33,000 cases of AIDS have been reported in the United States. Some 20,000 individuals have died from this deadly disease since it was first reported in 1981.

At least 1.5 million Americans have been infected with the virus. It is alarming that AIDS may soon become the tenth leading cause of death in this country.

The Surgeon General, C. Everett Koop, in his recent report on AIDS stated that, by the end of 1991—just 3½ years from now—an estimated 270,000 cases of AIDS will have occurred, with 179,000 related deaths. These numbers are disturbing. In an effort to address this problem, I was pleased last week to join with several of my Republican colleagues in introducing the Omnibus Acquired Immune Deficiency Syndrome Act of 1987, many features of which were included in legislation recently considered by the Labor and Human Resources Committee, of which I am a member.

Mr. Chairman, there is no escaping the sad fact that AIDS has also had an adverse impact upon the veteran population. As members of this committee, we must ensure that the VA Medical Centers provide an adequate level of care to AIDS patients. At the same time, we must not ignore other non-AIDS related health-care problems.

To summarize, any legislation from this committee must be carefully drafted to appropriately address this complex issue. Mr. Chairman, because of prior commitments, I will not be able to remain for the full hearing. I will look forward to reviewing the testimony of the distinguished witnesses.

I want to welcome all the distinguished witnesses here today, and I will read your testimony. I am sorry that I cannot remain. Thank you very much.

We will be in recess until the chairman arrives.

[Whereupon, at 9:39 a.m., a brief recess was held.]

[The committee reconvened at 9:45 a.m.]

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman **Cranston**. The hearing will come to order. I apologize for the slight lateness of our beginning. I am pleased to welcome all of you to the Senate Veterans' Affairs Committee's first hearing focusing exclusively on AIDS.

AIDS is clearly this Nation's and, very likely, the world's greatest health threat. Six years ago AIDS was unknown to the United States. Today, tens of thousands of Americans are suffering from illnesses caused by the HIV infection. AIDS has already claimed the lives of more than 20,000 Americans and an estimated 1.5 to 2 million more have been infected with the HIV virus. A majority of them will likely develop AIDS within the next 10 years. The count worldwide is equally alarming; between 5 and 10 million people may be carrying the virus.

We are in the midst of a terrible human tragedy. Unfortunately, in addition to the AIDS epidemic, we are also facing an epidemic of fear, fear that has resulted from a lack of information and education about AIDS. We also face the potential of a great epidemic of distrust, distrust that may result from policies that are being proposed for mass testing of individuals for the virus without the informed consent of those individuals. We must do everything to find a treatment, vaccine, and cure for AIDS as rapidly as possible.

We must be equally vigilant in our efforts to prevent further spread of the HIV infection. That means a major commitment to AIDS public information and prevention programs.

I am proud to have been at the forefront of congressional efforts over the past 6 years to provide the resources needed for such research, development, public information, and prevention programs. We have a long way to go, but we are on the right track, I believe, in terms of congressional initiatives. As we develop AIDS programs and efforts, we must listen to our public health experts and scientists, establish policies that are based on their recommendations, and not succumb to the panic and prejudice that so often accompany the debate on AIDS. Sound public health concepts—not ideology or partisan politics—must guide our decisions and policies regarding AIDS.

You will hear today from some important public health experts and learn what the VA—which operates the largest health-care system in the United States—is doing and can do to help stop the AIDS epidemic. The American people are looking to the Federal Government to help them understand the disease, to separate fact from fiction, to help quell the hysteria. Unfortunately, presidential leadership has been sorely lacking on this issue and still is.

Nearly 5 years after the Congress—over administration objections—first started force-funding various Federal efforts to combat AIDS, we still did not have a national policy or strategy for dealing with it. Indeed, the President made his first major speech on AIDS only a month ago, but no presidential action has been taken. Instead, Reagan appointees who are not doctors and who are not experts in this field are loudly advocating points of view at odds with the views of the President's own top health advisers. The results have been drift, disarray, and dismay. Thus, it becomes especially important that Federal agencies and officials with pertinent missions themselves take on a leadership role.

About 6 percent of all AIDS cases in the United States are being cared for by the VA. The VA has treated more than 2,000 people with AIDS since 1981 and will see about 1,300 this year alone. If the AIDS caseload continues at the same rate, the VA may see 14,000 AIDS patients by 1991.

Earlier this year, our committee included in its fiscal year 1988 budget recommendations $47.5 million in additional AIDS treatment funding for VA Medical Centers. Although this additional funding was not expressly assumed in the budget resolution that has emerged from conference, I will continue working to add it to the VA's fiscal year 1988 appropriations.

I was pleased to learn a few days ago that the VA, as I had been urging, recently provided $4 million in supplemental funding support to seven of its medical centers with the largest numbers of AIDS cases and will be pursuing this morning what basis will be used for making AIDS adjustments in the fiscal year 1988 allocations to VA Medical Centers. As I indicated at our May 21 hearing, I believe it is essential that VA Medical Centers provide comprehensive education, counseling, and other prevention activities for VA health-care workers and patients and a comprehensive public education program for all VA beneficiaries and their families.

The Surgeon General, Dr. C. Everett Koop, has done an outstanding job in his 1986 report on AIDS. I am pleased that the VA has made efforts to distribute this document. I believe that the VA must dramatically expand those efforts, and I will pursue that goal vigorously.

On the issue of testing, I oppose President Reagan's proposal to require routine testing of all veterans being admitted to VA hospitals. The VA sees about 1.4 million hospital inpatients each year. Thus, testing would cost at least $21 million and probably much more at commercial rates and with the necessary attendant counseling. The majority of VA patients are elderly men at very low risk for AIDS.

The National Academy of Sciences and the Surgeon General, as well as the American Medical Association, have already stated that mandatory testing of patients admitted to hospitals is not appropriate. Not only would such widespread testing be cost prohibitive and unmanageable, to use the words of the Surgeon General, but it is virtually impossible to guarantee confidentiality of medical records in a VA or in any hospital. Hence, individuals may be deterred from seeking medical help because of the fear of the information about their medical status will leak out.

Most public health experts urge that high risk and other individuals be encouraged to take the HIV test, be fully counseled about the pros and cons of having the test performed, and be given the opportunity to provide specific informed, voluntary consent before being tested.

The issues here boil down to whether patients will be given that opportunity or whether they will be required to take the test as a condition of being furnished care or whether their blood will be tested without their knowledge and consent. In seeking the cooperation of people with AIDS or ARC and those who have been infected with the HIV virus, the use of coercion or deception would seem to be a totally counterproductive approach.

Finally, with regard to research, the VA has been in the forefront of many biomedical breakthroughs. I believe that it can play a significant role in basic and clinical research on AIDS. It is essential, however, that Federal agencies supporting research on AIDS—the VA, HHS, and the Department of Defense—cooperate and coordinate their efforts to the maximum degree possible. The VA is an important component in our war against AIDS. To do its job effectively, it must be equipped with the resources it needs to perform these vital lifesaving and lifeprolonging activities.

The committee is very interested in the ideas and views of all of those appearing before us today. We thank them for their help on these vitally important matters. Frank, do you have an opening statement?

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman. I do. I wish the panelists good morning. I am pleased that we have such a distinguished group of experts here today to consider one of our Nation's foremost and serious health problems.

AIDS may certainly be a threat to our Nation. AIDS is estimated, as I understand it, to infect 1 out of every 30 males in the country. I have a difficult time accepting that type of statistic. I gather, however, that in many cases it is dormant; but it is certainly a sobering statistic. The consequences for our society are significant. We must initiate an appropriate procedure. I don't know that we know necessarily what that procedure should be. There is a substantial energy outflow that is out there, but is it appropriate and is it directed in the most effective manner?

Certainly as the Nation's largest health-care provider, the VA must play an important role in the fight against AIDS. However, their role cannot be considered in isolation. It must, in fact, be part of a national response. Such a response requires a clearly defined and articulated policy that has the support of the medical profession, policymaking officials and the American people.

I don't know, Alan, but I was somewhat frustrated in the debate that we had on the floor on AIDS because it was a debate based on a response from our colleagues to want to do something. Of course, we can always throw money at problems, but the question is: Is it the most efficient way to respond to the threat that is upon us? Obviously, that is what we are looking for.

Certainly a policy which identifies research, prevention, and treatment goals and sets in motion a mechanism to conquer this epidemic is our objective. This policy must be a compassionate one that recognizes the needs and hopes of persons with AIDS, but equally important, one that addresses the threat this disease poses to all Americans, present and future.

We also have the concern for individual rights and so forth. I believe that through the wisdom and collective efforts of those in the medical and related professions, we can find the answers. Now, I was shocked to learn some time ago that in one of the New York Veterans' hospitals, nearly one-third of the inpatients and outpatients were veterans receiving treatment for AIDS. The costs of this treatment is extraordinary. It is staggering in the sense of recognizing that we are not set up to provide for the costs of that type of care.

I think you would agree that it is not our intention to delude ourselves into believing that an answer to the AIDS mystery is going to be found overnight. We need only to look at records with regard to cancer. We have prime examples of effective treatment but ultimately a cure for those complex diseases are often slow and disappointing. Although we have made important strides after many years of a serious commitment to cancer research, there is much that we simply do not know and the research must continue. It is imperative that we develop and implement a definite plan, a plan for prevention and control of the disease.

Now, mandatory testing has been proposed as one method. There has been a lot of discussion on this issue. Various persuasive insights and arguments have been made on both sides of the issue, but the critical policy question remains to be answered. I, for one, am at this time reluctant to support such testing until we are satisfied that testing indeed is the most effective way to control and prevent the spread of AIDS. We look forward to your testimony specifically on those questions.

For example, who will have access to the test results? For what specific purpose will the test results be used? What are the confidentiality rights of a patient? What is the cost? Would our limited resources be better directed toward research, education, and treatment?

The question that I have, and I think it is a primary one, is that I assume that when veterans go into a hospital, as a matter of routine, there is a blood test that occurs—not specifically for the purpose of identifying AIDS. What further effort is needed to test a patient for the AIDS virus?

The obvious question is: Is that appropriate? We do it for other reasons and obviously for the ability to treat the patient for other diseases. It is a matter of routine. I would appreciate it if you would reflect in your testimony on this question because I think our concern is one of confidentiality and the rights of the patients.

There has been much criticism of the President's recommendation that the veterans be among those that are mandatorily tested in the inpatient/outpatient care. Recognizing that the President has control over a relatively limited number of health-care beneficiaries—the Department of Defense, the VA, the Federal institutions, and others—I think it would be unfair to suggest that he is picking out the veterans and not other groups. He is picking out those groups that are under Federal control, and the question is a legitimate one. That is, whether veterans should or shouldn't be included. As I said, I am reluctant to support it at this time, but I would appreciate your specific recommendations. We have an item in The New York Times today: Mandatory Tests for AIDS Virus Opposed by Doctors at the VA.

So, we will look forward to hearing your testimony. I think that the hearing today and the witnesses that are with us will shed much needed light on this subject and give not only this committee but the Senate a better opportunity to address what action should be taken. Thank you, Mr. Chairman.

Chairman CRANSTON. Thank you very much. Bob, do you have a statement?

Senator STAFFORD. Mr. Chairman, I have no opening statement. I am here to hear what the witnesses have to say.

Chairman CRANSTON. Thank you. Dennis.

Senator DECONCINI. No, I have no opening statement. Thank you, Mr. Chairman.

Chairman CRANSTON. We are starting out with a panel of Administration witnesses, consisting of Dr. John A. Gronvall, Chief Medical Director, Veterans' Administration, accompanied by Dr. Howard Cohn, Deputy Assistant Chief Medical Director for Clinical Affairs; Mr. Robert Lindsey, Director of Operations; Dr. Susan Mather, Chief of Pulmonary and Infectious Diseases; Dr. Richard Greene, Assistant Chief Medical Director for Research and Development; and Mr. Ralph Ibson, Deputy Assistant General Counsel; Dr. Jarrett Clinton, Deputy Assistant Secretary of Defense (Health Affairs) for Professional Affairs and Quality Assurance, accompanied by Col. William Bancroft, U.S. Army; and finally, Dr. James Curran, Atlanta, Georgia, Director of the AIDS Program, Center for Infectious Diseases, Center for Disease Control.

I have a great many questions that I want to pursue, and I know the others on the committee may well have the same number of questions in their minds. So, I would appreciate it very much if you would keep your answers as brief and to the point as possible and amplify in writing where needed.

I will be moving back and forth among the witnesses to ask questions on various subjects. John, would you now make your statement, please?

STATEMENT OF DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. HOWARD COHN, DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR CLINICAL AFFAIRS; ROBERT LINDSEY, DIRECTOR OF OPERATIONS; DR. SUSAN MATHER, CHIEF OF PULMONARY AND INFECTIOUS DISEASES; DR. RICHARD GREENE, ASSISTANT CHIEF MEDICAL DIRECTOR FOR RESEARCH AND DEVELOPMENT; AND RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL

Dr. GRONVALL. Thank you very much, Mr. Chairman. We have prepared a detailed statement, which I would request be made a part of the hearing record.

Chairman CRANSTON. It will be.

Dr. GRONVALL. And in the interest of time, I will make a summary opening statement. This disease, AIDS, a devastating disease, is emerging as the first major lethal worldwide epidemic or pandemic of the second half of the 20th century. The Veterans' Administration health-care system is a very major part of the resources that this country has to care for individuals suffering from AIDS and also to participate in research that will bring this disease under control.

From September 1983 to May 1987, 2,014 cases of full-blown AIDS have been reported in the VA.

Senator MURKOWSKI. Doctor, would you give that figure again?

Dr. GRONVALL. 2,014 cases have been documented in the VA of full-blown AIDS.

Senator MURKOWSKI. Would you define "full-blown" vis-a-vis "half-blown"?

Dr. GRONVALL. Yes, sir. The use of the term "full blown AIDS" means that the person is infected with the AIDS virus and has developed the active disease. The person's immune response system has been reduced, and so the person suffers from a complication, either an infectious disease or the development of one of the cancers.

Senator MURKOWSKI. I don't want to prolong this, but I made a statement that it is estimated that 1 out of every 30 males in this country is affected with the AIDS virus now. You can comment on the accuracy or the inaccuracy, but I assume my figure is not "full-blown."

Dr. GRONVALL. Your figure would apply to the number of people who have been infected with the virus, not the number of people who have gone on to develop the active disease state. And my figure of 2,014 cases are the cases that have the active disease.

Senator DECONCINI. Would the ranking member yield? I don't want to prolong the debate, but just for educational purposes, can you determine that someone is infected with the virus but does not have the so-called "full-blown" or the actual disease. Is that right?

Dr. GRONVALL. Yes.

Senator DECONCINI. Now, someone who is infected with the virus who doesn't have the actual disease, what is the prognosis or there is any on how many of those become full-blown and get the disease?

Maybe that is in your statement.

Dr. **Gronvall.** Yes, but this is a good place to comment on it. There are many individuals who have been infected; laboratory tests can show that they have developed antibodies to the AIDS virus, but they have no symptoms. It is not now possible to say with precision how many of those individuals go on subsequently to develop the active disease.

Senator **DeConcini.** You just don't know yet?

Dr. **Gronvall.** There are estimates that place that at something like one-third to as high as 75 or 80 percent. Our experience is growing, and so that is an answer that is evolving based on our experience.

Senator **DeConcini.** Thank you, Doctor.

Senator **Stafford.** Doctor, could you supply us for the record, if you can't do it now, the age groups involved in full-blown and otherwise infected veterans who have AIDS?

Dr. **Gronvall.** Yes. We would be pleased to supply the description of veterans who have the disease with those kind of categorizations.

Senator **Stafford.** We would appreciate it. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

Information on ages of VA patients with AIDS is not available on all patients in the AIDS registry. However, a manual compilation of the approximately 1,000 on which age and race or ethnic group data is available is being done and should be available by August 1, 1987. A survey of 90 patients discharged from VA medical centers in 1986 showed the average age to be 41.2 years with a range of 24 to 67. We will provide the compilation of information to the Committee when it is available.

Senator **Murkowski.** I just have a question. Is 1 out of 30 realistic, or am I all wet?

Dr. **Gronvall.** I think Dr. Curran from CDC is the best person to speak to that question.

Senator **Murkowski.** How many males are there in the country? About 100 million?

Dr. **Gronvall.** 120 million approximately.

Senator **Murkowski.** 120 million? How many of those are believed to be infected.

Dr. **Curran.** The 1 in 30 estimate was attributed to me via several newspapers, and it came from a presentation that I made at the AIDS Conference here in Washington. What I was doing was discussing the prevalence of infection in the United States, how many people are infected with the virus; and the discussion was that there had been ½ a million to 4 million. The Public Health Service has estimated that there are 1.5 million; and I was pointing out that 1.5 million is a large number indeed because, if they are distributed like the reported cases of AIDS—by sex and by age—that would mean that most of these 1.5 million people are men between the ages of 20 and 50.

And in fact, if there are 1.5 million infected Americans, that means that 1 in 30 men between the ages of 20 and 50 in the United States are infected with the virus. This number, of course, would be a great deal higher in New York and in California and other areas.

Chairman **Cranston.** That is a quite different statistic.

Senator **Murkowski.** Well, is it that different?

Dr. CURRAN. It is between the ages of 20 and 50, excluding people younger than 20 and older than 50.

Senator MURKOWSKI. In that range it would be, in your opinion, accurate?

Dr. CURRAN. I think that is pretty close, and it would be much higher in some areas.

Senator MURKOWSKI. So, you can assume then that these people are infected, have been infected through blood or sexual relationships. Is that correct?

Dr. CURRAN. The studies that have been done among people identified as infected would suggest that the majority have been infected—the vast majority—through sexual contact or intravenous drug abuse.

Senator MURKOWSKI. Thank you. Thank you, Mr. Chairman.

Chairman CRANSTON. John, your 5 minutes are now up. [Laughter.]

You may have a fresh start.

Dr. GRONVALL. All right, fine. The impact of this disease in the VA is heaviest on the east and west coasts, but actually 111 of our medical centers have had at least one case. As we look to the future, we have projected that we might have treated something like 14,000 cases by 1991.

Treatment of AIDS in our hospitals is complex and requires a very dedicated team of medical specialists and subspecialists and it also places an enormous burden on our nurses, social workers, and chaplains. We have tried to estimate the cost of AIDS care. In 1985, our estimate was that it was costing about $38,000 per year in the VA for each AIDS patient.

More recently, that figure has gone down as we have gained more experience, and we have had patients in the hospital shorter lengths of time and made less use of our intensive care units. At the present time, we are estimating something like $20,000 per year per patient; but because the total number of patients has increased remarkably, we have made supplemental funding allocations to our medical centers that have treated more than 15 cases.

And again, as we look toward the future, new drugs or new treatments that are developed might remarkably change the cost experience, either up or down. The advent of a new treatment that was itself very expensive could increase the cost of care or, more hopefully, an effective treatment or, better yet, prevention could of course remarkably reduce the cost.

Mr. Chairman, during the May 21 hearing, we discussed your suggestion that we expand our education efforts, particularly for high risk groups. I am pleased to tell you that we agree with this suggestion, and we are now developing an educational program on AIDS that will be a routine part of all of our substance abuse programs.

We are working closely with other Federal agencies. That collaboration includes the Department of Defense, the Department of Health and Human Services, Centers for Disease Control; and we participate actively on an intergovernmental task force on AIDS health-care delivery.

In regard to research, I should just note that the Veterans' Administration is engaged in the entire spectrum of research on

AIDS. We are conducting basic science studies on the mechanism of action of the AIDS virus infection. We are engaged in clinical trials of drug treatment. And one study is particularly important to take note of; we are carrying out a large-scale controlled clinical trial to see whether the drug AZT will prevent patients who have so-called AIDS-related complex from progressing on to full-blown AIDS.

I should perhaps expand a little on that in view of the earlier questioning. When a person is first infected, there may be a period during which the individual has no symptoms. There is then, in many patients, a period of time characterized by the term "AIDS-related complex," during which some symptoms occur, such as swelling of the lymph nodes, but not one of the terribly serious or lethal complications; and the trial that we are conducting identifies patients during this phase of the disease, and we are using the drug AZT to see whether it will prevent progress of the disease from AIDS-related complex to full-blown AIDS. This trial, in fact, is supported by research funds made available from the Department of Defense.

My concluding comment would be that, as we look forward to the future, I think it is very hard to predict or project with accuracy the health or social consequences of this disease; but our commitment in the Veterans' Administration is to ensure that we do not overlook any opportunity to contribute to bringing this terrible scourge under control.

At this moment, we are taking steps to strengthen the organization of the Veterans' Administration to ensure that we can better plan our patient care activities, our research, and our educational contributions. And we very much appreciate the interest and support of this committee as we continue with this work. Mr. Chairman, that is a brief opening statement, but we will be pleased to respond to questions.

Chairman CRANSTON. Thank you very much, Dr. Gronvall. Dr. Clinton.

[The prepared statement of Dr. Gronvall appears on p. 81.]

STATEMENT OF DR. J. JARRETT CLINTON, DEPUTY ASSISTANT SECRETARY OF DEFENSE (PROFESSIONAL AFFAIRS AND QUALITY ASSURANCE), OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, ACCOMPANIED BY COL. WILLIAM BANCROFT, MEDICAL CORPS, U.S. ARMY

Dr. CLINTON. Thank you, Mr. Chairman. We are very pleased to be a part ot this hearing and have an opportunity to tell you and the public about the programs and policies of the Department of Defense. We have already prepared for you a written statement that describes much of our data and information, the programs and the policies. I assume that will be a part of the record. We request that it be so.

Chairman CRANSTON. Yes, it will be.

Dr. CLINTON. What I would like to highlight at this time is the distinguishing characteristics of our actions which are to focus predominantly on the infection with HIV virus, the human immunodeficiency virus. The AIDS cases, while real and substantial in the military, do not make an enormous burden on our medical care system at this time. I think the distinguishing characteristic of the Department of Defense actions began almost 2 years ago, to identify those individuals who have the infection and the infection alone, and find ways to prevent their progression to more serious complications of that infection, to prevent the spread of the infection in our own community and the public at large.

Now, about 2 years ago, the first action was taken to test all civilian applicants to the military. Now, we have tested nearly a million people who have applied to the military and have a constant rate of approximately 1.5 positives per 1,000.

Chairman CRANSTON. Is that when somebody applies to become a member of the military?

Dr. CLINTON. That is correct.

Chairman CRANSTON. All such people are tested?

Dr. CLINTON. Every one, whether it be for Officers Candidate School or whatever category it might be. They are all tested.

Senator MURKOWSKI. Does that include the National Guard?

Dr. CLINTON. Yes. 1.5 per 1,000, and strikingly, that rate has stayed approximately the same. There are no significant statistical changes of any consequence over an 18-month period.

Chairman CRANSTON. What is the rate again?

Dr. CLINTON. 1.5 per 1,000. That would be 3 people in 2,000. There is a good deal of variation in those rates as you look to those applicants who come from New York City and in parts of California, as opposed to the Midwest; but nonetheless, that is the average rate.

Now, not long after that, we established a policy of testing all those in the Active Force; and we have nearly completed that. The rate there is very similar. More precisely, it is 1.6 per 1,000. Now, we have an Active Duty Force of slightly over 2 million people. We have identified approximately 3,000 individuals, in round numbers, who are infected with this virus.

More than half of them have no other pathology, no other symptomatology of a disease. The other half have, in varying degrees, pathology with about 4 percent of those having the definition of disease AIDS. You can see that the majority of the people that we are dealing with now are early in the infection. As has been noted earlier, we are not sure to what extent these people will progress to either ARC or AIDS.

That, we think, is providing very useful information to the Centers for Disease Control. We have provided for the written record some of the reports on the civilian applicant data that are routinely reported by CDC to the profession and the public at large. And through various professional presentations, we provide data with regard to the demographics of our own testing of the Active Duty Forces.

We believe that by preventing those with the infection from joining the Active Duty Forces and by screening those and curtailing their assignments to the United States and watching them very carefully from a medical standpoint, we will reduce the impact of the infection on our own military force and, in the long run, on the VA's medical efforts.

We hope then that this combination, combined with our information and education program, can indeed make AIDS and the infection with HIV as minimal as might be possible within our community. Thank you, Mr. Chairman.

Chairman **Cranston**. Thank you very much. Dr. Curran.

[The prepared statement of Dr. Clinton appears on p. 91.]

STATEMENT OF DR. JAMES W. CURRAN, DIRECTOR, AIDS PROGRAM, CENTER FOR INFECTIOUS DISEASES, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. **Curran**. Thank you, Mr. Chairman. I am very pleased to be here to represent the Centers for Disease Control; and we, too, have provided written testimony for the record.

I would like to make a couple statements in addition to the written testimony. First, cooperation and communication with both the Veterans' Administration medical group and the Department of Defense about the incidence and prevalence of AIDS and reported AIDS cases as well as AIDS antibody testing has been quite helpful to the CDC in terms of providing information that can be of use in understanding the problem in the United States.

Second, since the disease was discovered 6 years ago, there have now been reports of cases in 112 countries throughout the world. It is truly a worldwide health problem, and there is worldwide medical and scientific and public health expertise to draw from to deal with the problem. There may not be enough people working on it, but there are certainly many people with a lot of experience.

As I pointed out, cases are reported from all 50 States, the District of Columbia and Puerto Rico. In most of the cases thus far, over 90 percent have been in homosexual men and heterosexual intravenous drug abusers. I think it is important to note that, in Dr. Gronvall's testimony and in our testimony and that of the Veterans' Administration, about 40 percent of the cases have been in heterosexual men and women who are intravenous drug abusers. And to my knowledge, about 4 percent of the cases in the United States are related to heterosexual contact with men and women who are infected with the virus.

Many people fail to understand that the majority of heterosexual contact and perinatal transmission in the United States thus far has been directly or indirectly related to intravenous drug abuse. Intravenous drug abuse is at the very roots of the heterosexual epidemic in the United States; and of course, controlling heterosexual transmission will be inextricably linked to the control of intravenous drug abuse.

I don't know of any other sexually transmitted disease in heterosexual men and women in a country which has begun with intravenous drug abuse and has been so closely linked to intravenous drug abuse.

There is a great deal that is known about AIDS, and there is also a great deal that is unknown; and I think that we have publicly had a lot of uncertainty about what is known and what is unknown. Some scientists say we are totally perplexed in our search for a vaccine. That we need to understand the immune system more completely; and that there is a struggle to come up with safe, effective therapies. However, there is a great deal known about modes of transmission, and it is important not to mix up what is known about the modes of transmission with the lack of knowledge in some of the more basic scientific areas.

One important question that has been referred to is the outcome among infected people. What will happen to someone who is infected with the AIDS virus? Let me make a couple of comments about that.

Infection with the AIDS virus is probably lifelong—almost certainly lifelong. It is a persistent infection which continues to damage the immune system of the infected host. AIDS, the very serious life-threatening infections and cancers, is the end of that infection process, the end of the spectrum.

People are often asymptomatic for the first few years. And there are now at least 20,000 infected people who are involved in prospective studies to study the outcome in them. Because AIDS has been so recently recognized, virtually none of these 20,000 people have been followed for more than 7 or 8 years. The most extensive study is one in San Francisco, with the San Francisco Health Department and CDC, in which nearly 7,000 homosexual men have been followed, actually retrospectively, since 1978.

In that study, fewer than 1 percent of men infected for 2 years have developed AIDS; but by the end of 7 years, 30 percent have developed AIDS. And in those who have died AIDS has been been the cause in 95 percent of those deaths. So, it is far and away——

Chairman CRANSTON. 95 percent?

Dr. CURRAN. 95 percent of the men in the cohort. Of the 6,700 men, average age 32, over 700 now have developed AIDS. There are many other issues that I will be willing to respond to with questions; I see my time is up. Important questions are incidence of prevalence and infection. CDC is involved in surveillance, epidemiologic studies, and prevention and control. With regard to prevention and control, the efforts are aimed at the general public, school age and school children, infected people and people at highest risk, as well as health-care workers.

The testing and counseling issue primarily involves those people at high risk for infection. One comment I would like to make about testing and counseling is that the objectives of it are to provide counseling to infected people primarily and counseling to people who are at increased risk for infection. Testing without counseling is not likely to be very productive.

Another major objective is for diagnostic purposes. I think Dr. Rowland, in his House testimony, said that telling someone they are infected with the AIDS virus is like telling them they have cancer; and the first thing you want to know is: Doctor, what are you going to do for me? And I think that is the first question that the VA will answer and anybody else will answer.

Chairman CRANSTON. What response are you able to give to that question? Or what answer is a doctor able to give to that question?

Dr. CURRAN. I think a doctor has to be very knowledgeable about the current state of the art in terms of therapy and outcome. What I would tell a patient is that, among homosexual men, most people remain without symptoms for 2 years. Thirty percent of people will develop a life-threatening disease within 7 years; 70 percent won't.

I would say that there are a lot of studies to try to determine which people will and which people won't, that there are some additional tests of your immune system that we can do to help differentiate your status, and I would like to follow you very closely. If you need more time for discussion psychologically, et cetera, I will provide you with additional help. I would like to say my door is always open. Things like that.

Confidentiality in record keeping are particular problems in hospitals, and there has never been a disease in which confidentiality is more of a problem than AIDS. So, that is something that any hospital has to deal with when they start to do routine testing.

Last, is the training of health-care workers. Since the beginning there has been a concern about the role of health-care workers in caring for people infected with the AIDS virus. This has been intensified with reports of infection in health-care workers that have been occupationally exposed. These occupational exposures are rare, but——

Senator MURKOWSKI. On that point, we have heard so much about the rights of the AIDS victim. What about the rights of the nurse? Are the nurses—those persons who have to give the individual care all the time, as opposed to the doctors who come in and out—demanding that they have advance notice of whether they are likely to be treating AIDS infected patients so that they can take precautions? What about their rights?

Dr. CURRAN. The issue of precautions for health-care and laboratory workers was addressed in 1982, about 2 years before the AIDS virus was discovered, because of the concern that this was caused by something that was circulating in blood. The precautions that are necessary for health-care workers are really necessary for all health-care workers exposed to blood and body fluids, irrespective of whether they know the antibody status or not because most people infected with the virus are not going to have AIDS.

In an outpatient setting, for example, where there could be no way of knowing the test results ahead of time it is going to be important for all health-care workers to take precautions—wear gloves. If they are involved in a procedure where body fluids might be splattered they should wear goggles and masks. It is important that they take these precautions irrespective of the question of whether they know the antibody status of the patients.

We think it is an open question of whether knowledge of antibody status increases precautions that health-care workers take. In one way, you could argue that it would. It may also diminish the care for the patient if they were to be avoided or isolated, in terms of their medical care.

I think that is a very important question to answer, and undoubtedly there will be more demands for testing for that reason.

Chairman CRANSTON. We are going to hear from a representative of the American Nurses' Association this morning. Does that complete your statement?

Dr. CURRAN. Sir, that completes my time. [Laughter.]

Chairman CRANSTON. If there is anything else you have an urgent need to communicate, don't hesitate. Otherwise, we will start asking questions.

[The prepared statement of Dr. Curran appears on p. 117.]

Chairman CRANSTON. John, I would like to ask you first if you have any comments on this New York Times story that appeared today on page 1, indicating that you oppose mandatory testing of VA hospital patients.

Dr. GRONVALL. I have read the story, of course, Mr. Chairman; and the story accurately states that I was interviewed yesterday by the reporter, who asked questions about the position of the Veterans' Administration. When I discussed it with him, I indicated that we had made recommendations to the White House work group which, in turn, would be the subject of deliberation at the Domestic Policy Council and that, since that recommendation is a confidential recommendation from the Veterans' Administration, I couldn't really discuss what was included in that recommendation.

Chairman CRANSTON. Is the story in the New York Times accurate?

Dr. GRONVALL. I have read it with great interest, but——[Laughter.]

But not from the standpoint of detailed analysis to compare the story with VA documents; but I believe the story, on first reading, appears to be accurate.

Chairman CRANSTON. Thank you very much.

Senator MURKOWSKI. A good answer.

Chairman CRANSTON. Yes. Could you make a copy of the memo referred to and quoted available for the committee?

Dr. GRONVALL. Mr. Chairman, my understanding of that, is that, of course, the document that we provided to the White House was a confidential recommendation from the Veterans' Administration; but with that understanding, if it is requested by the committee as a part of your oversight role, we can make the document available to you, with that understanding that it is a confidential document.

Chairman CRANSTON. I do so request on behalf of the committee.

Dr. GRONVALL. Thank you. We will supply it.

Chairman CRANSTON. Thank you very much.

[Subsequently, the Veterans' Administration furnished the following information:]

The paper on AIDS testing was provided to the committee by letter and dated July 2, 1987.

Chairman CRANSTON. What specific guidance has the VA provided to its field facilities with regard to testing for the HIV antibody?

Dr. GRONVALL. I will ask Dr. Cohn to describe that. We have been very concerned, and we have issued a great deal of very specific guidance to our field facilities. Dr. Cohn?

Chairman CRANSTON. All right. Dr. Cohn, if you would reply very briefly now and give us more for the record?

Dr. COHN. We have issued 17 circulars, Senator, and we have three additional ones in draft, doing a life history of our involvement with the AIDS epidemic. A number of those circulars deal with the issue of testing. The two cardinal areas that we have given guidance have to do with, first of all, Project Lookback, or Program Lookback, which as you know is related to the blood transfusion issue; and the other area is the use of the AIDS antibody test as a clinical guide to aid the physician in making a diagnosis.

So, essentially, the guidance is in those two general categories. We have also had opportunities to discuss with individual facilities the desirability of providing voluntary testing for special groups at risk, namely patients who are in our drug abuse units.

Chairman **Cranston**. What have you told the local people about informed consent and counseling?

Dr. **Cohn**. Very well. As far as informed consent, that categorically must be obtained; and that is part and parcel of AIDS antibody testing. That informed consent should take the form of an exchange of information with the patient about the disease, the purpose of the test; that obviously the results of the test will be discussed with the patient.

And the second part of your question, sir?

Chairman **Cranston**. Is that noted in the medical record?

Dr. **Cohn**. That should be noted in the record. Yes, sir.

Chairman **Cranston**. Is counseling also provided?

Dr. **Cohn**. Counseling also is a part of the testing, and that should be provided both pre- and post-test and is.

Chairman **Cranston**. Thank you.

Dr. **Gronvall**. Mr. Chairman, I might just add a sentence. We have been concerned to ensure that that policy on informed consent is uniformly followed up and carried out. So, as recently in fact as last week in a conference call to all of our medical centers, we reminded our medical center personnel of the need to have informed consent in every case, to have that documented in the record, and to ensure that counseling before testing and after testing was done in every instance.

Chairman **Cranston**. Thank you. John, could you give us your personal and professional views of the proposal to test all inpatients in VA Medical Centers? What I would like to ask you to do is to comment specifically on each of the following, if you can: The need or lack of need for such testing; the need or lack of need for pre- and post-test counseling; the need or lack of need for informed consent; the cost of the proposal; and your ability to guarantee the confidentiality of test results.

Dr. **Gronvall**. Yes, sir, I would be pleased to comment. In fact, I am unaware of a proposal by anyone that we establish as a mandatory process testing of every veteran who comes to us for care. The President, in his public statement, called for a review of the issue of testing in the VA; and that review has been under way, and it led to the preparation of the document that we were discussing earlier.

Chairman **Cranston**. Such a proposal may well come from some authoritative place, so I would like to get your professional and personal views of that approach.

Dr. **Gronvall**. I think our view has evolved in consultation with the CDC and Public Health officials. And our view is that testing should be focused on those groups of veterans where there is reasonable likelihood of a payoff by testing and that the requirement for counseling before and after testing is an absolute imperative. It is our stated policy that all testing should be done with informed consent. We have uniformly felt very strongly that the patient needs to be aware that the test is being performed and why it is being performed, since our desire is to have the patient cooperate with his or her physician in changing behavior or doing whatever is necessary, both in the patient's best interest and in the best interest of contacts with the patient.

So, we have continued to insist on counseling and informed consent. In regard to confidentiality, we view the results of the test as a confidential part of the medical record, entered into the patient's medical record, but that that confidentiality exists with regard to this medical information in the same way that it does with any other diagnostic information.

Within the hospital, the staff immediately responsible for care of the patient, of course, need to know what the patient's medical condition is; but, as has been commented earlier, all of the workers in a hospital need to conduct themselves and take care of patients and take care of the facility in such a way that they are protected from the risk of infection. That includes hepatitis and other infectious diseases, of course, as well as AIDS.

So, we have educated our entire staff through extensive training programs to ensure that they conduct themselves in a safe fashion.

Chairman CRANSTON. What would you estimate the cost of such a program to be?

Dr. GRONVALL. The cost estimates, based on our current experience, are that the preliminary screening test for AIDS is costing us about $5 per test, and then the corroborative test costs about $17. If we have a positive result or a questionable result and require so-called tertiary testing, which is a more elaborate series of tests, that can run up to approximately $100 per specimen.

Chairman CRANSTON. If you were going to have a program of testing everybody who came into the VA and also had to give pre- and post-test counseling—go through all the procedures—what would the total cost be?

Dr. GRONVALL. I don't have a figure that I could give for that.

Chairman CRANSTON. Could you furnish it for the record?

Dr. GRONVALL. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

> Since a testing program of this magnitude has not been undertaken before, it is difficult to estimate exactly how much it would cost. Our best estimate for a testing program that involves a "screening" ELISA with confirmatory Western Blots and pre- and post-test counseling is $24,855,000 per year. This does not include followup examinations and care for those veterans identified as HIV positive.

Dr. GRONVALL. During any individual year, we have medical contact with about 3.5 million veterans. A testing program that was expanded to that extent could reduce the per-test cost. Our estimates, based on experience, are that the counseling part of the testing program is in fact more expensive than the laboratory component and is, as I said, an extremely important part of the testing.

Chairman CRANSTON. I guess the number of inpatients would be 1.4 million. Right?

Dr. GRONVALL. Yes. We hospitalize about 1.4 million veterans per year.

Chairman CRANSTON. If it was decided that the VA should implement mandatory AIDS testing programs, do you believe it would have the statutory authority to condition eligibility for VA hospital care—which for 95 percent of your patients is an entitlement—on the testing being performed on them?

Dr. **GRONVALL**. That, of course, is a legal question; and I would like to ask Mr. Ibson to comment.

Chairman **CRANSTON**. Fine.

Dr. **GRONVALL**. My understanding is that at present we would not have such authority. Mr. Ibson?

Chairman **CRANSTON**. Mr. Ibson?

Mr. **IBSON**. Thank you, Mr. Chairman. I would have to say that we have not undertaken a definitive legal analysis of that question.

Chairman **CRANSTON**. Let me ask a follow-up question of you. Does the VA believe it has the statutory authority to conduct the test on a patient's blood without that patient's informed consent, or at least without offering the patient a right to refuse?

Mr. **IBSON**. My preliminary view would be that informed consent is a prerequisite, sir.

Chairman **CRANSTON**. If you would give a detailed answer in writing to both questions, the preceding one and that one, I would appreciate it.

Mr. **IBSON**. We will be pleased to do so. Thank you.

Chairman **CRANSTON**. Thank you.

[Subsequently, the Veterans' Administration furnished the information which appears on p. 132.]

Chairman **CRANSTON**. Given that many VA Medical Centers are expanding their voluntary testing programs, does your Lexington Laboratory presently have the capacity to meet these growing demands?

Dr. **GRONVALL**. We are equipped now to do very sophisticated testing, not only at Lexington, but at a number of our other facilities. We have expanded our capability of testing so that we can do the full range of testing not only at Lexington, but at New York, Albuquerque, San Francisco, Denver, and New Orleans. And we are continuously reviewing our laboratory capability to expand that capacity.

Chairman **CRANSTON**. Could you presently process all VA tests if all inpatients were screened?

Dr. **GRONVALL**. If a decision were made to screen all VA inpatients, it would require some time to gear up the laboratory capability to do that.

Chairman **CRANSTON**. What plans, if any, do you have to establish such labs at other VA Medical Centers?

Dr. **GRONVALL**. Dr. Cohn might comment on that.

Dr. **COHN**. None other than as Dr. Gronvall read, sir. I would just want to add that I think our Lexington reference lab is reaching the point of being overloaded at the present time with a modest testing program that I addressed in your earlier question. So, clearly, there would have to be the establishment of other labs or contracting out to do the entire population.

Chairman **CRANSTON**. Would you compare the costs of analyzing the test in-house and by contract?

Dr. **GRONVALL**. At the present time, our in-house experience is that it is cheaper than having it done on a fee basis. Our full statement has some example figures. I mention that a screening test costs us about $5 per test. Our private sector fee basis experience is that that same test runs from $12 to $30. We have additional data that we could supply on the more elaborate testing in regard to our cost versus the contract cost.

Chairman **CRANSTON**. If you had a large expansion of the testing, would you have to go to contract?

Dr. **GRONVALL**. It would depend, I think, on the timetable and availability of funds as to whether we could expand VA laboratories sufficient to meet that program.

Chairman **CRANSTON**. Thank you. Frank, my time is up.

Senator **MURKOWSKI**. Thank you very much, Mr. Chairman. From the questions that you were posing and those that I have and the other members have, it will be somewhat representative of the general process here and the extent of concern and probably show the basic ignorance that exists on the issue. I would like to go back to this figure that I used and that Dr. Curran qualified, the qualification being males in the age group of 20 to 50 and that being a correct interpretation. If indeed 1 of 30 have been infected in the age group of 20 to 50 males, provide the number that you are using, Doctor, in the sense of how many individual males are infected and how many of those are aware of it?

Dr. **CURRAN**. My estimate is coming full circle in the sense that it began with an estimate of how many people were infected, that is 1.5 million.

Senator **MURKOWSKI**. 1.5 million?

Dr. **CURRAN**. 1.5 million total. And in the 20 to 50 age group in men, over 90 percent would be men.

Senator **MURKOWSKI**. Yes.

Dr. **CURRAN**. And in the 20 to 50 age group, about 90 percent of those men would be included. So, over a million would be in that group, if 1.5 million people are infected.

Senator **MURKOWSKI**. Right. Now, out of that million, how many are knowledgeable that they have the infection?

Dr. **CURRAN**. We have those people who have been diagnosed with AIDS who are living; that is about 15,000, plus another 7,000 to 8,000 yet to be reported. We have people who have been tested through blood bank screening programs and through the Department of Defense, the Foreign Service, Job Corps, and other programs, where testing is done. We have people who have gone to federally supported testing and counseling sites, and there are estimated to be 50,000 who have been tested and counseled through the CDC supported sites.

All of this comes out to a reported estimate, I guess, of approximately 10 percent.

Senator **MURKOWSKI**. Ten percent?

Dr. **CURRAN**. Approximately.

Senator **MURKOWSKI**. Of the million?

Dr. **CURRAN**. Approximately.

Senator **MURKOWSKI**. About 10 percent know it; the rest don't.

Dr. **CURRAN**. It is likely that there are additional people who have AIDS related illnesses who have gone to private physicians, who have been tested and the results haven't been reported, for example. So, we don't know about those.

Senator **MURKOWSKI**. Either they know they are infected or they don't.

Dr. **Curran**. The bottom line answer is that well more than half of those persons infected—whatever the number of infected is—probably are not personally aware or have not been personally counseled.

Senator **Murkowski**. All right. In your professional opinion, do you feel that there is justification that those that don't know that they have been infected know it? Is society going to be better off?

Dr. **Curran**. I think it is quite important for people to have counseling and testing and for people who are infected to know it because I think they can make more informed choices.

Senator **Murkowski**. Then, if you don't have some kind of a mandatory blood testing, how are those people going to know it?

Dr. **Curran**. I think there is no question that increased testing and counseling—increased coverage particularly of those populations likely to be infected—is a major objective and a major goal. What are the barriers to getting that done?

One of the barriers is increased resource availability, not just money, but also people to do the counseling and testing. I note that, of the patients reported at the VA hospitals, over 50 percent are Black and Hispanic. In the United States, about 40 percent of patients are Black and Hispanic. Many people, especially in minority populations, may not have a doctor. They don't have anybody to go to.

I think it would be very important to turn the 1.5 million people over to concerned physicians and concerned counselors. I would love to have that happen.

Senator **Murkowski**. Sure, but those people don't know if they are infected, and you don't know who they are.

Dr. **Curran**. The other thing to point out, I think, is that there are lines at testing and counseling centers around the country. I am told in California you wait 4 weeks to get tested in some centers. So, there needs to be a lot more testing.

Senator **Murkowski**. How are we going to get there from here if there isn't some kind of mandatory testing because these people aren't necessarily going to go and say I want a test for AIDS. Something may motivate them; they might recall an experience, and they may decide that they want to make that decision for themselves. But you are not going to pick up a very large percentage of this infected group that is out there that doesn't know that they are infected unless there is some method to do it.

Just as an example, we had here—after Senator Zorinsky's unfortunate passing—a cholesterol test offered in this building. Now, it was almost an instantaneous operation. You went down and you got a little quick prick in the thumb, and you were advised what your cholesterol count was. Is there a methodology associated with blood testing that can be done in a very expeditious manner where something like that would offer an individual a voluntary option to ask that his blood be examined for AIDS as well?

Dr. **Curran**. There are 1,200 federally supported testing and counseling centers throughout the United States, and many of those centers are State controlled and federally supported. In many of those centers, tests can be done anonymously, and people can pick up their results anonymously. I think that that is a valuable thing, but the concern I have about it is that, if you have a very elevated cholesterol, that is nice to know; but what are you going to do about it? You have to go to a cardiologist or somebody who can tell you just exactly what that means for your own personal life.

I think that is the same thing with the AIDS test. I personally believe that everybody who is infected with the virus, and everybody who is at any increased risk, needs to know a lot more, and they need to know if they are infected.

Senator MURKOWSKI. Yes, but you are leaving me hanging, Doctor, because how am I going to get that done?

Dr. CURRAN. I think we need to make it a standard of medical practice, for one thing.

Senator MURKOWSKI. You are implying, then, a mandatory screening of some kind, without saying so.

Dr. CURRAN. I don't think I am implying mandatory. I like the word "routine" pretty well.

Senator MURKOWSKI. All right. I will buy that. [Laughter.]

But how do you motivate people to be tested? A few minutes ago, you said in the blood testing program, you have some tests for AIDS; but does somebody have to sign, or do you anonymously test? You see, there is no definitive anthology here.

Dr. CURRAN. It might be useful to discuss the word "mandatory" from the point of view of what it means to the person on the other end of the needle. If an elevated cholesterol meant that you couldn't be in the Senate any more—and I am serious—that would be a problem—and the mandatory testing programs have been in blood banks and in recruits to the military. And the result of the word "mandatory" from the point of view of those who are going to get tested is that people can't donate blood and they can't enter the military if they have a positive test. Now, if the perception of the public is that, on a national testing day, all Americans get tested and something bad will happen as a result of that, in addition to finding out that they have a deadly disease, there is going to be a lot of public resistance, even among people who aren't at risk. So, the word "mandatory" is an extremely loaded word on both sides.

I mean, virtually no test is mandatory on hospital admission. Many are routine.

Senator MURKOWSKI. All right. Let's take your word "routine." Do you mean in the process, which becomes routine, of taking blood samples that there be an AIDS test given as well?

Dr. CURRAN. I think in that 20 to 50 year age group and in many hospitals and health care settings AIDS testing ought to be at the top of every doctor's thoughts, in which case they shouldn't just wait to question people about their risk. They ought to be routinely offering the test to every patient in that age group.

Senator MURKOWSKI. Where does this conflict with the headline in The New York Times that says "Mandatory Tests for AIDS Opposed by Doctors"? Would you accept that if it said "routine AIDS tests"? You tell me how to get there from here, gentlemen. Am I expressing a dilemma that I am not sharing with you? Dr. Gronvall, maybe you can help enlighten us on this. You heard Dr. Curran's statement that the routine aspect of it would give you a window into those million-plus that are out there that don't know.

The VA tells us that mandatory AIDS testing is opposed by doctors at the VA. How do you bring "routine" into "mandatory" to make it acceptable, if indeed it is?

Dr. GRONVALL. I don't know that the two terms can be harmonized.

Senator MURKOWSKI. Address the objective then because that is really what we are all trying to develop—a process that is workable, that is supportable, that addresses the rights of the individual and their privacy, and yet benefits the public health.

Dr. GRONVALL. Yes. In my view, it is a highly laudible goal that, in the health-care system, every individual who comes to a physician, a clinic, or a hospital and falls into either an age group or a category of symptomatology or a characteristic of lifestyle or other disease, that means that that person is at some significant risk of being infected with the AIDS virus, that that person be routinely counseled by his or her physician that testing for the infection of the AIDS virus is highly desirable. What that would mean and what the individual could do about it, if it turns out that the individual is in fact infected, in that context I believe a major expansion of routine testing targetted on certain categories of individuals coming for health care is desirable.

Senator MURKOWSKI. How do you motivate that group of individuals in the age group of 20 to 50? Public pronouncements that they are a high-risk group?

Dr. GRONVALL. The context, of course, of my comment is that the individual has come to a physician or a clinic for some reason. I am not making a comment on a population-wide epidemiologic survey. I think that is quite a different matter.

My comments are restricted really as the responsible person for a health-care system. My comments are restricted to those individuals who, for some reason, come to us seeking care or come with a concern. I believe many individuals are coming to doctors and clinics because they are concerned about the possibility they might be infected with AIDS, and they are asymptomatic; and we are seeing increasing numbers of such people come.

Senator MURKOWSKI. I accept that, but by the same token, Dr. Curran referenced that there are a million people out there, and 90 percent of that age group of 20 to 50 probably are not necessarily aware of their infection. We are assuming that they are going to be motivated simply because they are in that age group, to come in and voluntarily make a determination. I guess time will tell whether that is enough.

Dr. GRONVALL. Yes.

Senator MURKOWSKI. We will have to see if we can initiate a process that is workable or whether there will have to be some exterior force to motivate this group. That is what I am concerned about. I think you are giving us a very qualified answer, and I appreciate that, but by the same token, we have a responsibility of initiating a reaction that is representative of the people. I don't know that that qualification, as broad as you have presented it, is really going to get us there in a time frame that equalizes the tremendous spread and advancement of this disease in the last 6 or 7 years. That is what I am concerned about. I guess I have one last question, Mr. Chairman.

What do you think the Congress or the Senate of the United States should be doing, other than holding hearings and talking about it? The No. 1 thing that should be done that is not being done is what?

Dr. Gronvall. That is a very important question, I think, but an extraordinarily difficult one to capture the complexity of this epidemic into one overriding objective. I think that the Congress should do everything it can to ensure that there is accurate information available for portrayal to the public, do everything it can to best ensure that the many activities throughout the country in terms of patient care and research and education are coordinated in some sense, even if it is only through the availability of information about what is going on.

And I think by these kinds of hearings and others, stimulate the development or existence of perhaps a more coherent set of activities—research, education, and patient care throughout the country. I think to confront this disease is going to require the best efforts of every sector of a highly pluralistic health system and social system in this country. I am not an advocate of a national plan in the sense of the creation of a czar—a single individual or a single ironclad plan—that mandates everything that should be done because I think that sort of approach misses the genius of the pluralism and dynamism of America; but I believe presenting the information to the public and working to ensure that our efforts are known across the range of the health system and are coordinated and then providing the resources to capitalize on every possible opportunity as it presents itself to improve our education and our research and patient care activities is the objective.

Senator Murkowski. Thank you, Mr. Chairman. I have some other questions, which I will ask Mr. Principi to submit for the record.

Chairman Cranston. Thank you very much, Frank.

I presume part of your answer would be that Congress should pay particular attention to health professionals in seeking advice as to what we can do?

Dr. Gronvall. Yes, sir. I think expert medical and scientific advice is a key component of dealing with a disease whose solution ultimately will come out of research and understanding of the characteristic of the virus and its mode of action.

Chairman Cranston. Bob?

Senator Stafford. Thank you, Mr. Chairman. Gentlemen, the Chairman and the Ranking Member of the committee have asked most of the questions that might have occurred to me. And indeed, they have asked several that did not; but one has occurred to me that I would like to direct, to Dr. Curran.

We have listened to a considerable discussion of the incidence of the disease, the prospects for handling those who have or may have the disease, or preventing its spread. But nobody has said anything about the possibilities of better treatment for the disease than we have had up until now. I wonder, Doctor, if you could comment on where we are in trying to find something that will not only stop but cure this terrible disease?

Dr. Curran. Doctors Gronvall and Clinton may want to add something to this. In my written testimony is a discussion of the clinical trials that are being supported by the National Institutes of Health. There is approximately $100 million in the Public Health Service budget for therapy studies.

Currently, there is one drug that is licensed for the therapy of people who are infected with the AIDS virus, and at this time use of that drug is restricted to people who have been diagnosed as having AIDS. Some additional studies being conducted at the VA, at Walter Reed, and other places may extend the use of that drug. The drug, azidothymidine, is a drug that is very expensive and has considerable toxicity but does prolong life and improve the well-being of people in this select category of patients.

There are many other drugs. This drug and other drugs being tested do not eradicate the virus. They do not cure the person, but merely hold it in check to prevent it from reproducing as quickly. So, there is not yet any sort of magic bullet. There is a lot of effort in this area; and there is one drug licensed.

Dr. **GRONVALL**. I think it would be helpful for Dr. Cohn to comment.

Chairman **CRANSTON**. I would appreciate that.

Dr. **COHN**. There are three broad approaches to the treatment and, hopefully, the ultimate cure of AIDS. One is the antiviral approach. Dr. Curran has alluded to the one drug that is available in the marketplace.

Second, so-called immune modulators; and third, vaccine. You have probably heard and read a fair amount about vaccine effort. Most experts predict that we are probably 3 to 5 years away, at least, from having an effective vaccine, maybe longer. The point I would like to make is that there is a tremendous amount of activity in all of these arenas.

There is a tremendous flurry of activity among researchers. I think the Third International Conference on AIDS, which was held in Washington, is but one rather graphic example. One could hardly move about in the hallways and corridors at the hotel where it was held because there were so many, many people—literally thousands of people.

There have been tremendous contributions in our system, of course, at NIH and elsewhere in terms of delineation of the virus and assorted other work. It would appear that the best and ultimate approach would probably be a combination of these different modalities, that one treatment alone will probably not do the job as you are asking, that it will be a combination approach that will be the ultimate solution to the disease.

Senator **STAFFORD**. Thank you, Dr. Cohn. Thank you, Mr. Chairman.

Chairman **CRANSTON**. Thank you very much, Bob. I would like to ask Mr. Ibson regarding the legal opinions that I requested, could you please give us those by July 6?

Mr. **IBSON**. We will make every effort to do so, Senator.

Chairman **CRANSTON**. Thank you. Colonel Bancroft, I would like to address some questions to you. What does it cost the Army to perform each test at the present?

Colonel **BANCROFT**. The tests that we do are done by contract laboratories. We estimate that they are approximately $5 a person at the present time.

Chairman CRANSTON. Could you give us a list of those laboratories for the record?

Colonel BANCROFT. Yes, I certainly can.

Chairman CRANSTON. I think the VA estimated it would cost substantially more than that.

Colonel BANCROFT. We have been able to contract at a lower price because of the large volume.

Chairman CRANSTON. That doesn't include any cost of counseling, does it?

Colonel BANCROFT. No, sir.

Chairman CRANSTON. What are counseling costs per test? Or do you know?

Colonel BANCROFT. The counseling costs I could not estimate. They would be built into the regular costs of medical care.

Chairman CRANSTON. Are the Army's costs typical of the costs of other services?

Colonel BANCROFT. Yes.

Chairman CRANSTON. How are the tests processed? For example, does the Army have one centralized laboratory facility for processing the tests? What about the other services?

Colonel BANCROFT. The Army has most of their tests done by the Damon Laboratories, which is a contract laboratory located in Texas, with a subsidiary laboratory in California. Each individual has an initial immunosorbent test done. If that is negative, it is not repeated; and the individual is considered negative. If it is positive, it is repeated.

Chairman CRANSTON. Would you amplify in writing just how the other services proceed?

Colonel BANCROFT. Yes, sir.

[Subsequently, Colonel Bancroft furnished the following information:]

All HIV testing for all Services follow the same procedures: each individual has an FDA approved enzyme linked immunoassay serologic test and, if positive, an immunoelectrophoresis test (Western Blot). Special tests are done if the Western blot analysis is indeterminate.

The contract costs are as follows:

U.S. Army

All HIV testing for the civilian applicants and the active duty, reserve and National Guard is done by Damon Laboratories of Needham Hieghts, MA. The cost per person tested is:

	Total people	ELISA + Western Blot
Civilian Applicants	747,000	$4.10
Active Duty Army	456,624	$3.99
Reservists	277,000	$9.29 (+ blood drawing)
National Guard	290,763	$9.55 (+ blood drawing)
Special purpose individual tests:		
Western Blot		$13.77/test
Recombinant ELISA		$ 6.33/test

U.S. Navy/Marine Corps

ELISA tests are done by Electronucleonics Inc., Bethesda, MD and Western Blots by Biotech Research Lab, Rockville, MD.

Active Duty and Reserves:		
ELISA	800,000	$ 0.62/test
Western Blot		$30.00/test

U.S. Air Force

All tests are contracted to Blood Systems Inc., Scottsdale, AZ.

Active Duty, Reserves and National Guard:		
ELISA	404,000	$ 3.51/test
Western Blot		$14.13/test
Special Purpose Tests:		
Recombinant ELISA		$11.91/test
Indirect Fluorescent Antibody		$ 9.37/test

Chairman CRANSTON. Thank you very much. John, back to you. One scientific article has reported that when the antibody test is applied to a low-risk population, the false positive rate is very high, that is, for every 28 HIV positive individuals that the test would correctly identify, the test would also incorrectly identify as being HIV positive 11 individuals who turn out really not to be. What false positive rate have you found?

Dr. GRONVALL. I would like to ask Dr. Cohn to supply that answer.

Dr. COHN. Our overall experience is roughly along the same lines, Senator. Let me explain this way. The reason for the higher rate of false positives in a low prevalence population is because those individuals are not AIDS antibody positive. They have a low level of other kinds of antibodies that all of us have. These antibodies are so-called cross reacting antibodies, and they actually will react with the test materials, often in an equivocal way; but that equivocal response may be replicated and lead to a final conclusion by the laboratory technician as a positive, when indeed it would be a false positive.

And of course, the implications would be devastating to the patient; that is one of our particular concerns about mandatory or wide-scale testing particulary among such low prevalence populations.

Chairman CRANSTON. Then, even with first-class lab chemicals and equipment and expertise in performing the test, there will still be a large number of false positives, particularly in a population of individuals like VA hospital patients who are ill and are on a number of medications. Is that correct?

Dr. COHN. Generally, that is correct, particularly among patients who are ill; I think that is the key word in your question. Patients with cancer, for example; patients with autoimmune disease.

Chairman CRANSTON. Or people that come to hospitals?

Dr. COHN. People that come to hospitals.

Chairman CRANSTON. Who are often ill.

Dr. COHN. This is often true. [Laughter.]

But not universally.

Chairman CRANSTON. I would like to ask about one seeming discrepancy, for which there may be a rather simple explanation; this 1 in 30 figure that Senator Murkowski was asking about is in sharp contrast to the figure of those who apply to join the military and it seems like it was more like 1.5 in 1,000 or something like that there. Is that because people who may well be infected know they are going to be tested don't come? Or is it because people in the groups that are particularly susceptible don't come? Or how do you explain the difference between those two figures?

Dr. CURRAN. The 1 in 30 estimate came from another estimate, which was the estimate of the number of infected Americans being 1.5 million. If you take the age and sex adjusted military recruit data and extrapolate that to the U.S. population, you come out with something like 270,000 infected Americans. So, there is a sixfold age and sex adjusted discrepancy. I believe the major part of the discrepancy is that homosexual men and current intravenous drug abusers are strongly discouraged from entering the military and don't go to testing stations. That is probably the major discrepancy and there probably are other discrepancies as well. The military data has got to be a tremendous underestimate of the number of infected Americans.

Chairman CRANSTON. Do you have any comment on that?

Dr. CLINTON. No. The only thing I would add is that the average age of the military recruit applicant is, of course, much younger and would probably be below the 20 to 50 age group, right at 19 or so.

Chairman CRANSTON. Yes.

Dr. CLINTON. So, it does not reflect the age distribution of America; that may be part of it. How much of that affects it, no one knows at this point.

Chairman CRANSTON. Colonel Bancroft, what false positive rate have you found in screening military recruits?

Colonel BANCROFT. We find the false positive rate is less than—certainly less than—2 percent and usually less than 1 percent. Using the quality assurance standards that we have set up for the performance of the contract laboratories with rigid quality assurance standards and set criteria for positive interpretation, the performance of the test, and the submission of coded panels to the laboratories, so that the tests are done on a consistent basis from month to month, we find that the false positive rates are very low. Again, our testing system is based on the premise that we do not want to have false positives. And if we do call an individual positive, since it does affect his employment, we want to be absolutely sure we can back that up.

Chairman CRANSTON. I presume that the group you are working with would be in a healthier state than those that show up via hospitals; that would be one explanation. If you can provide us with data, both of you, on this, we would appreciate it.

[Subsequently, the following information was furnished:]

There are no data nor information regarding the state of health of recruit applicants and tested active duty members compared with individuals seeking healthcare services in military treatment facilities.

Chairman CRANSTON. Dr. Curran?

Dr. CURRAN. I would like to make a statement on the false positive issue. I think that it is important to recognize that there are at least two tests done. The first is the ELISA test, which is then confirmed by doing a Western blot test or some other procedure. When those tests are done by competent laboratories, I think the military, the Red Cross, and other groups that have been screening low prevalence populations have shown that there are relatively few errors when those tests are done in the appropriate sequence.

Another important point, though, is that it is extremely important to do both tests when there is a positive result because in a low prevalence population the first test may provide misleading results. I think the military and the Red Cross would both say that, before you notify the patient, it is necessary to do both tests. That takes additional time, and it is not something that would be done within the first few hours of hospital admission, but would probably take a few days.

Dr. **Gronvall.** If I may, Mr. Chairman, just add one final sentence to that perspective? In regard to testing blood that is collected for a blood bank, of course, the intent of testing is quite different and the action in a sense is simple. If there is a test which is positive or questionably positive, you can discard the unit of blood and not use it for transfusion. So, the intent of testing when you are protecting the safety of the blood supply is one thing. Now, it is a quite different matter when you are dealing with individual patients being tested to see whether they are infected and whether you need to counsel them as to their own risk of a deadly disease.

Chairman **Cranston.** Given the seriousness, John, of a positive test result and the stigma associated with that result, in your personal opinion does not the potential for harm in testing low incidence populations outweigh the small potential benefit?

Dr. **Gronvall.** That calls for a judgment, and I would find it hard to weigh exactly in any kind of quantitative way. It is clear that a false positive result has a devastating impact on the individual. And as I had said earlier, I believe testing should be done with individuals who are at some risk and should be done under the best of circumstances with appropriate counseling and elaborate efforts to ensure that we absolutely minimize false positives and that we engage the patient's cooperation in what is going on so that we have the best opportunity to work with the patient, to encourage him or her to change whatever is possible to be changed so that we get the best total outcome for the patient's well-being and the well-being of contacts.

Chairman **Cranston.** Dr. Curran, do you have any comment on that issue?

Dr. **Curran.** I think we have had a similar situation with syphilis testing, where the false positive rate for the VDRL, or the common screening test for syphilis, is actually substantially higher than it is for the HIV antibody test. Then, another test is done afterward. I myself have had a false positive syphilis test, and I didn't find that particularly alarming. I think the Red Cross has screened 20 million blood donors and has notified those people who have a positive confirmatory test, and I have not even heard—and I would expect it would be in the newspapers—of people who were having problems in that regard.

I think the military has notified a lot of people, too. So, I think it is a "handleable" problem in terms of a false positivity rate. In my opinion, that is not the major issue.

The major issue is: What do you do with a positive—a real positive? And what are you going to do for that person?

Chairman **Cranston**. I recently learned, John, that at one VA substance abuse clinic, 30 percent of the patients on the methadone program are positive for the HIV antibody. Do you have any data overall regarding the percentages of patients at other VA substance abuse clinics who have AIDS or have tested positive?

Dr. **Gronvall**. Dr. Cohn or Dr. Mather, could you help me? I am not aware myself.

Dr. **Cohn**. No other statistics, sir, but that would fall totally within keeping of tests that have been done in the private sector as well as the public sector of patients attending methadone maintenance clinics. For example, in Newark and Jersey City, the positivity rate—the seropositivity rate—is as high as 70 percent in some of those centers.

So, that 30 percent would be totally in keeping with such centers.

Chairman **Cranston**. It seems to me that substance abuse centers are ideal settings for the VA to provide education and outreach for a large number of individuals who are obviously at high risk for AIDS. What kind of education, counseling, and testing are you offering presently to individuals seeking treatment at those centers to encourage them to be tested?

Dr. **Cohn**. In response to your question today, and indeed you brought up the same point, I believe, at the May 21 hearing, we have addressed the question to the 10 leading facilities that are identified in Dr. Gronvall's opening statement. And we are planning to have a formal patient health education program addressed to that population covering a wide variety of areas which I won't take the time to enumerate for you now, but can be provided for the record.

Chairman **Cranston**. Will that be aimed at encouraging these people to get tested?

Dr. **Cohn**. That would be part of the aim. Yes, sir.

Chairman **Cranston**. I should think that should be a very significant part.

Dr. **Cohn**. Yes, sir.

Chairman **Cranston**. If you could give us some more detail on how that program is operating for the record, I would appreciate it.

Dr. **Cohn**. Fine.

[Subsequently, the Veterans' Administration furnished the following information:]

The 10 VA medical centers currently with the highest number of AIDS cases reported Patient and Family Education activities in all of the topics listed below. This information is available to inpatients, outpatients, veterans in the community through VA Health Fairs as well as VA staff participating in community activities including community nursing homes, volunteers, families and significant others, recovering drug abuse patients, worried well (exposed to virus and/or HIV positive), and Zidovudine (formerly called AZT) drug Protocol participants.

The Mental Health and Behavioral Sciences Service is preparing a program guide entitled "Mental Health Issues Regarding AIDS." The program guide will draw from onging programs in several VA medical centers and similar programs in NIDA. It will address AIDS patients education as well as staff approaches to AIDS patients.

The Office of Academic Affairs (OAA) is establishing a comprehensive VA-wide AIDS Patient and Family Education Program. By the end of July, OAA will provide a profile of VA medical centers (VAMCs) AIDS Patient and Family Education activities and programs. This assessment will include program components, target audiences, print and non-print materials supporting educational activities, and the name of contact person by VAMC and will provide the information necessary to assist those VAMCs that need help in developing effective patient health education (PHE) program related to the following information:

—HIV screening and/or results.
—Confidentiality and privacy of individual infected with AIDS.
—Cause of AIDS.
—Major avenues of transmission.
—Methods to prevent spread of AIDS.
—Difference in "high risk" and "low risk" activities.
—Difference between infected with HIV virus but asymptomatic, AIDS-Related Complex (ARC), and AIDS.
—Treatment of AIDS.
—AIDS support groups.
—AIDS as public health issue and impact on society.
—Followup and availability of outreach program services such as housing, shopping, transportation, cleaning, cooking, finance, job counseling, emotional support, testing centers for family and significant others, home care, barbers, legal issues, wills, etc.
—Look Back Program related to blood transfusion.
—Principles of infection control; skills in home care for care giver.
—Clinical Drug Trial Programs.

During July, the PHE Conference Call will focus on AIDS Patient and Family Education activities and programs. This conference call is directed to all VAMCs and will highlight effective PHE activities and programs.

In addition, the OAA conducts monthly bibliographic citation searches on AIDS and distributes this information to Regional Medical Education Centers (RMECs), Cooperative Health Manpower Education Program (CHEPs), and chairpersons of VAMC PHE Committees. A search for audiovisuals related to AIDS has been conducted and distributed to RMECs.

Dr. GRONVALL. Mr. Chairman?

Chairman CRANSTON. Yes?

Dr. GRONVALL. There has been a good deal of discussion today about statistics and the need to clarify the record. If I may, I would like to make a comment on an earlier statement made here that, at one of our Veterans' Administration hospitals, something like one-third of the patients in the hospital have AIDS. I believe I can correct that.

Chairman CRANSTON. I don't believe I meant to say that.

Dr. GRONVALL. No, it was said earlier. And again, in the interest of having an accurate public record, I ask to correct that. The hospital being referred to was our New York hospital, I believe—Manhattan. That hospital has had the greatest incidence of AIDS. Recently, we have surveyed all of our hospitals, and the Manhattan hospital, at any one time, will have something like 20 AIDS patients hospitalized in the hospital. That hospital has some 600 beds, and that figure of 20 AIDS patients then, compared to the total hospital bed complement, would result in something like 3 percent of the total patients in that hospital being hospitalized for AIDS. We do not have any hospital that approaches 30 percent of its patient population having AIDS.

Chairman CRANSTON. Good. John, the ANA's written testimony cites reports that a list of VA patients tested for HIV was found in an accessible photocopy at a VA facility after it was inadvertently left there. Do you know of any other incidents like that?

Dr. GRONVALL. I have not read that testimony, and I was wholly unaware of the incident referred. And I have not had any report made to me that there has been any breach of confidentiality of the record system in the VA. So, I will certainly look into that. That is the first I have heard of such a case.

Chairman **Cranston**. If that is true, let me ask you, why would such a list be compiled and why would it be photocopied?

Dr. **Gronvall**. Of course, I don't know the answer.

Dr. **Cohn**. I have no answer.

Chairman **Cranston**. Will you endeavor to find the answer to that?

Dr. **Gronvall**. We absolutely will. As I said, I was unaware of that, but we will surely followup on that immediately. I am very anxious to continuously take steps to protect the confidentiality of our records. I appreciate anyone bringing a problem to our attention, and we will immediately followup on it.

Chairman **Cranston**. That is one that obviously needs explanation.

Dr. **Gronvall**. We absolutely will.

[Subsequently, the Veterans' Administration furnished the following information:]

An investigation is underway, and we will provide the results of that investigation when available.

Chairman **Cranston**. John, the city of San Francisco has developed a very successful model for caring for AIDS patients. It provides a continuum of care which includes home and other community-based noninstitutional care and hospice care, but it has no long-term beds available for AIDS patients.

Do you have plans to develop a strategy for meeting long-term institutional care needs of veterans who have AIDS?

Dr. **Gronvall**. Yes, we have worked on that; and it is part of the planning activity that I referred to that needs to be strengthened in the VA. I think each of our medical centers that experiences a heavy volume of AIDS-related patients is searching for the best way to approach this very difficult disease, and we are hoping to work out ways in which we can document and test different approaches, including the one that you described.

Chairman **Cranston**. I assume you know there is an effort under way in Congress to transfer from the Army to the city of San Francisco the former Public Health Service Hospital there that was returned to the Army back in 1981. If this transfer goes through, the city would utilize the hospital as a nursing home and other long-term care needs for AIDS patients. If such a facility is indeed established in San Francisco, do you believe that the VA might be interested in entering into an agreement with the city of San Francisco whereby the agency would be able to utilize some of the nursing home and other long-term care capacity of the facility for VA AIDS patients? It seems to me that you are going to need long-term care beds for AIDS patients in San Francisco, and there are virtually no such beds available in San Francisco.

Dr. **Gronvall**. Yes, you are certainly right. I am aware only generally of that proposal, but we would be very anxious to be part of that deliberation. And wherever we have a documented need for such extended care beds, that kind of potential would be of great interest to us and the kind of general relationship you describe where we contract for that kind of care is something that we would be anxious to explore and do, if it could serve the purpose of facilitating care of veterans.

Chairman **Cranston**. This may be a question again for Mr. Ibson, but do you believe that you have sufficient legal authority to enter into that kind of agreement?

Dr. **Gronvall**. Yes, I believe so, but that is a very general answer; and again, it would depend on the particular eligibility of the individual veteran.

Chairman **Cranston**. Dr. Curran, if I could turn to you, with regard to the same issue, the Army has recommended that, instead of it directly leasing the facility to the city of San Francisco, it turn the facility over to the Public Health Service which would, in turn, lease it to the city. Since the facility will be used as a health care facility, I think that that proposal makes good sense. The facility represents a unique opportunity to learn about extended care needs and programs that will be increasingly in demand as this epidemic worsens. I would very much hope to have the department's cooperation on that issue. Could you ask Secretary Bowen for his views on the feasibility and advisability of such a proposal, and get back to us in the next few days with his response?

Dr. **Curran**. Yes.

[Subsequently, Dr. Curran provided the following information:]

In an April 14, 1987 memorandum from Assistant Secretary Dr. Robert Windom to Dr. Sheridan L. Weinstein, PHS Regional Health Administrator for Region IX, regarding the potential use of the former San Francisco Public Health Service Hospital as a facility for the care of people with AIDS, Dr. Windom stated:

"I do not see the return of the PHS Hospital to a federally managed facility as a feasible option. However, I feel that if the City and County of San Francisco either alone or in cooperation with neighboring health departments would be interested, they might pursue options for use of space in the building as a subacute care facility for people with AIDS." Because responsibility for the building now rests with the Department of Defense, Dr. Windom stated further: "Whether space in the building could be secured from the Army is another matter which the San Francisco health officials would have to address once they have formulated a plan for its use."

[Note.—On December 4, 1987, the President signed Public Law 100-180, the National Defense Authorization Act (H.R. 1748) which includes a provision directing the Secretary of the Army to lease the former Public Health Service facility to the City and County of San Franscisco for an AIDS/ARC treatment center. According to the statement of the congressional conferees on the legislation, the lease will be entered into no later than January 1, 1989.]

Chairman **Cranston**. John, back to you. On an unrelated but not totally dissimilar issue, drug testing of VA health workers, I am deeply concerned that the VA not move ahead in any new testing program without first providing this committee a full description and cost estimate of the program.

I would also urge that the VA's testing program be carried out in full compliance with criteria that all other Federal agencies must adhere to. And finally, I believe that no testing program should be implemented at the VA unless there is a specific appropriation for that purpose. Funds should not be siphoned off from direct patient care programs for the purpose of testing VA employees. I will likely pursue legislation to effectuate these three purposes regarding VA employee drug testing.

What is your current policy with regard to drug testing of DM&S employees and applicants for employment generally, or in a particular program like substance abuse?

Dr. **Gronvall**. As a general statement, we are working, of course—along with other Federal agencies—to develop a description of an expanded drug testing program that might be put into effect for employees within the VA. I am unaware at the present time of any drug testing program that operates within the Veterans' Administration, although it has been brought to my attention that in some our drug abuse programs there is screening of people working in the drug abuse program. I don't have definitive information on that. Dr. Cohn, could you help me?

Dr. COHN. I have no more data.

Dr. GRONVALL. As I say, we are developing a plan for the capability of an expanded drug testing program, which has not been put into operation as yet.

Chairman CRANSTON. Further, on health employee drug testing, what are your personal and professional views about drug testing on each of the following points? First, should testing be conducted routinely on all DM&S employees or only based on reasonable suspicion?

Dr. GRONVALL. I do not believe that it would be appropriate to conduct drug testing on every employee in the Department of Medicine and Surgery. I believe the purpose of drug testing is to focus on individuals whose level of responsibility or activity or whose behavior or work performance is such that it is important to assure that the person is not under the influence or using drugs; and so, the testing should be targetted or focused in that way.

Chairman CRANSTON. If routine testing were to be pursued, should it be random or announced?

Dr. GRONVALL. Again, that is a question I don't think I can answer with a very substantive answer because it depends on the purpose, I think, of the testing. And I think in some instances, there is a rationale for random or unannounced testing; but as a generalization, I believe testing is better done when it is announced and the individuals who are going to be tested know the purpose of being tested, and it is announced in a planned program.

Chairman CRANSTON. How often should Government employees be tested?

Dr. GRONVALL. Again, that is a question that I don't think I can answer. It depends upon the particular kind of drug and the individual circumstance as to how often there needs to be assurance or a repeat look to see whether the person is free of the influence of drugs.

Chairman CRANSTON. Is there any reason to believe that drug abuse is a significant problem among VA health care workers?

Dr. GRONVALL. I have no reason to think that there is a unique kind of problem among VA health care workers. Our staff, of course, come from the general population; and so, the drug abuse problem in America means that we are not immune to that problem among our employed staff. We judge the quality of performance of every one of our staff, and so we judge people primarily on their performance. And I am not aware of either any data or assertion that we have a particular problem in the VA.

Chairman CRANSTON. Do you have a personal or professional opinion on the efficacy of testing for drugs but not for alcohol?

Dr. GRONVALL. I think I don't quite understand the context of that question.

Chairman **CRANSTON**. Does it make sense to test for drugs but not for alcohol?

Dr. **GRONVALL**. If the purpose of testing is to gain assurance that individuals who are taking care of veterans are not under the deleterious influence of a substance, then alcohol abuse and drug abuse certainly fall under the same banner and can have the same negative effect on the person's ability to do a job. So, in that context, both are of great concern.

Chairman **CRANSTON**. Thank you very much. Dr. Curran, it is clear that there is heavy pressure from OMB, the Domestic Policy Council, and elsewhere in the administration, with regard to this testing issue. The Secretary of Education and others without public health backgrounds or operational responsibilities are taking firm public positions in sharp variance with what leading public health authorities are meanwhile advising. I think that, in this time of great anxiety, the American public needs to know that it is getting the best possible advice from our public health officials, and that it is advice based on sound public health policies, untainted by any political considerations.

The CDC has a hard-won reputation as a reliable source of sound scientific judgment, unmixed with political concerns.

It has consistently been a voice of reason. It has consistently given guidance and assistance on the most controversial issues that have arisen concerning AIDS. For instance, whether children of AIDS should be excluded from schools and what steps health-care workers should take to prevent exposure to the HIV virus. I was very pleased that when the issue of mandatory testing first came up, CDC held a conference to hear differing viewpoints and to reach a concensus on the appropriateness and feasibility of various testing programs. I think CDC was able to make some very sound recommendations as a result of that conference, and I am confident that we can continue to count on you for that type of courageous and needed leadership.

There will be many times in the weeks and years ahead when those of us in political positions will be confronting policy decisions with respect to testing, discrimination, and possibly even quarantine relating to AIDS. In those situations we will be looking to our public health officials for their counsel as to what courses of action are wisest from the public health standpoint.

We must be able to get that advice straight, if it is to be of value. If the advice we get is skewed by political considerations before it emerges, I then would be concerned that we could be misled into making some mistakes that could be disastrous. Dr. Gronvall, as that story on the front page today of the New York Times makes clear, the same is true with respect to the VA. I believe that you are under the same kinds of pressures, and I congratulate you on the strength of character and leadership that you are displaying on these issues, which I know are very, very tough to handle.

Now, I would like to ask Dr. Curran about a report issued by the CDC on April 30, 1987. That report entitled "Recommended Additional Guidelines for HIV Antibody Counseling and Testing and the Prevention of HIV Infection in AIDS," presented a summary of proceedings from a February meeting on that subject, as well as

CDC's recommendations that evolved from the meeting. Is it correct that that report has not yet been formally approved?

Dr. CURRAN. That was the CDC report to the Public Health Service.

Chairman CRANSTON. Did Dr. Windom approve it?

Dr. CURRAN. I believe it is under consideration by the Public Health Service.

Chairman CRANSTON. What about Dr. Bowen?

Dr. CURRAN. He is Dr. Windom's boss.

Chairman CRANSTON. Yes. So, there has not yet been an approval there?

Dr. CURRAN. It has been submitted.

Chairman CRANSTON. Has it been submitted to the OMB for approval?

Dr. CURRAN. I don't know. I think it is in the Public Health Service being considered.

Chairman CRANSTON. Could you find out if it has gone to OMB or if it is scheduled to go to OMB?

Dr. CURRAN. The answer to both these questions is no.

Chairman CRANSTON. Dr. Curran, in the April 1987 CDC document on testing and counseling, the CDC calculated, I believe, that at a minimum it would cost more than $18,000 to detect and counsel a single infected person through routine screening of low risk populations. Is that a correct estimate?

Dr. CURRAN. I think you can take the $5 average and if you have a population where 1 per 1,000 is infected, it is $5,000. Counseling would add another $25 to $45 to that. So, even in a population of 1 per 1,000, you are talking about numbers in excess of that.

Chairman CRANSTON. What would be the total figure then? Do the mathematics for us.

Dr. CURRAN. You probably have a copy of the report. You may be more familiar with it than I am—the details of it. If you can give me the page number——[Laughter.]

I think it was page 4 in the draft.

Chairman CRANSTON. Their estimate was $18,000 to detect and counsel a single infected person through routine screening of low risk populations. Do you consider this to be a cost-effective method for reaching and educating people about AIDS?

Dr. CURRAN. I believe that dealing with infected individuals—the low risk is 1 in 10,000——

Chairman CRANSTON. What is that?

Dr. CURRAN. I believe that routine testing and counseling of moderate to high prevalence populations is perhaps the most important thing we can do. Now, your question about the substance abuse programs, those allow us to find people, many of whom demonstrate addictive behavior and who need—in addition to testing and counseling—readily available drug treatment. Many people in the heterosexual populations, like their spouses, and many people in minority communities are totally unaware that they have been infected with the virus.

There was a study presented at the International Conference on AIDS by Dr. Menkoff and Dr. Landesmann, where they tested pregnant minority women living in Brooklyn—at one hospital in Brooklyn—and 2.5 percent of the women were infected with the virus.

They had to do the test on a research basis at the time. Most of these women had no idea that they were at risk and they were already pregnant. That is important information when these women consider their next pregnancy and when they consider family planning.

Therefore, particularly in the populations where people have no inkling that they might be infected, I think it is probably not too much money to spend. It is related to what is going to happen after the test result, the availability of the resources to make that happen. So, I think whether it is $18,000 or $8,000 or $4,000 is not as important as what you are going to do when you get positive results. Then there are going to be some additional expenditures there.

Chairman Cranston. I take it that you feel that routine testing of low risk segments of the population is not a good investment?

Dr. Curran. I think we don't know very much about the prevalence in most settings. We don't know just exactly what we will find when we do much of this routine testing. People were very, very surprised to find that 2.5 percent of the pregnant population in Brooklyn, for example, even though it was predicted. I think many hospital settings could do surveys to find out—whether they are anonymous or blind surveys—as we are doing in some 10 or 12 sentinel hospitals around the country—and see what the prevalence really is.

Chairman Cranston. I felt that Senator Murkowski wasn't getting guidance from you in his effort to get guidance on what is a very delicate and important point that he was pursuing. And that is, where there are high risk groups that may well be infected, many individuals don't know it and are, therefore, quite possibly spreading the contagion to others quite innocently. What can be done to reduce that risk? How do we go about persuading those people to be tested so that they can take precautions to protect others? That was the point that was concerning Senator Murkowski, and it is an obvious, legitimate concern.

Dr. Curran. I think it is easy to discuss whether mandatory testing should or shouldn't be done and whether other measures ought to be taken, but we have to sit back and ask ourselves why it isn't being done. It isn't just because some people are for it and some people are against it; and the people who are against it are winning, and the people for it are catching up. It is more of a question of what it takes to do it.

Let's say there are 100,000 people in substance abuse treatment programs in the United States that are under State and local control through block grants and have a certain amount of medical care available to them. Some of the counselors in these programs are people who used to be patients, and they are already overwhelmed. And 25 percent of the patients are infected with the AIDS virus. How do we get to making sure that every single person is tested and gets adequate medical care in those communities and all of their families get tested and get adequate medical care and family planning services and things like that? Some people are afraid to go in those neighborhoods. I mean, it isn't as simple as just being for it or against it. It takes a real bipartisan, nonpolitical commitment to do it.

Chairman CRANSTON. To do what?

Dr. CURRAN. To provide testing, counseling, and medical care for all infected people. There will be resistance to it, but I think if people felt that at the end of every test there was a doctor, instead of a loss of job or loss of insurance, they would be more willing to do it.

Now, not everybody would be willing to do it, but I would rather see a doctor at the end of every test than a pink slip.

Chairman CRANSTON. Dr. Curran, in regard to the demographics of VA patients, do you consider them representative of the general population and, thus, a good source of epidemiological data regarding the spread of the virus in our population?

Dr. CURRAN. I think generally yes; subtlely, no, in the sense that the AIDS patients themselves have included all aspects of the general population; but the patients in the VA hospitals have been heavily weighted toward men who are more likely to be veterans, as opposed to women. They have been more weighted toward Black and Hispanic minorities than AIDS patients in the general population and more weighted toward people with a history of IV drug abuse as the risk factor as opposed to homosexual transmission. In the latter regard, I think it is filling a need even if the data is disproportionate.

Chairman CRANSTON. Do you believe that the three recently reported incidents in which health-care workers became antibody positive after exposure to blood could have been prevented by adherence to the CDC guidelines?

Dr. CURRAN. I think all transmissions are not going to be prevented by the adherence to guidelines, simply because everyone isn't going to adhere; and that is human nature. In the three most recent cases that were reported, two of the health-care and laboratory workers were not wearing gloves. One of the nurses was trying to save the life of somebody in an intensive care unit in a hospital where there had been no cases of AIDS previously. The person could not have been tested because the patient just came in and died.

To say that this person should have put on gloves before she did the lifesaving maneuvers, I think, smacks of blaming the victim, in my opinion. On the other hand, a couple of the other cases and many of the needle stick cases have resulted from people not either knowing or following precautions such as recapping needles or handling blood without gloves on and things like that—coming into contact with body fluids.

Chairman CRANSTON. Do you think that health-care workers should adhere to those guidelines as a matter of course in treating all patients?

Dr. CURRAN. Absolutely. I think that one benefit that we have seen from concern about AIDS has been the increased compliance of dentists and hygienists with wearing gloves and masks. I had observed over the last 6 years a tremendous change in my own dentist and hygienist, and I think many of us have. That will also prevent a lot of Hepatitis B and other infections. There has got to be a lot more training for health-care workers in this area.

Chairman CRANSTON. John, would that be your view also?

Dr. GRONVALL. Absolutely.

Chairman **Cranston**. Dr. Clinton, does the department require that any pretest counseling be provided to any individual to whom the test is being administered?

Dr. **Clinton**. Yes. It is very clear that there is an education process prior to the testing of the active duty individuals, as well as a post-test, both evaluation and counseling. Often times, if you look at how that is done on the military base, there is a meeting of a battalion or a group of individuals, and there is information about what this program is, what we are trying to accomplish, how it is good for them, how it is good for the military. There may be a film; all services have films, some created by themselves. Others utilize films from the Public Health Service, the American Red Cross, and other sources.

And then, at the end of that information program, the testing is actually accomplished where blood may be drawn on, say, 100 individuals at one time and then sent to the contract laboratories. That is a long way of explaining how it is done; but as you would expect in the military, it is usually done in group batches if you will.

Chairman **Cranston**. What goes on in pretest counseling for recruits?

Dr. **Clinton**. That is fairly minimal since they are simply showing up, and they are advised that they are going to be tested for that. I think that there is not a great deal done with regard to the implications of it.

Chairman **Cranston**. What about post-test programs?

Dr. **Clinton**. They are advised to seek local assistance wherever that may be. Since these are not beneficiaries of the Department of Defense, we are troubled with that problem and have only been able to help the individual find assistance through the family physician. Of course, there won't be any in a number of cases since community resources for counseling are growing in the areas where the prevalence of the disease is highest, then community resource assistance usually can be arranged; but we are aware of significant difficulties in that regard.

Chairman **Cranston**. You wouldn't cover the cost of any counseling by the family physician?

Dr. **Clinton**. No.

Chairman **Cranston**. Would you supply for the record all the copies of policy directives that relate to counseling that you have issued?

Dr. **Clinton**. Yes.

[Subsequently, Dr. Clinton furnished the following information:]

The relevant portion of the DoD Policy on Identification, Surveillance, and Administration of Personnel Infected With Human Immunodeficiency Virus, dated 20 April 1987, follows:

(a) Upon notification of an individual with serologic or other laboratory or clinical evidence of HIV infection, the cognizant military health authority shall undertake preventive medicine intervention including counseling of the individual and others at risk of infection such as his or her sexual contacts (who are military health care beneficiaries) regarding transmission of the virus, coordination with military and civilian blood bank organizations to trace back possible exposure through blood transfusion or donation of infected blood, and referral of appropriate case-contact information to the cognizant military or civilian health authority.

(1) All individuals with serologic evidence of HIV infection who are military health care beneficiaries shall be counseled by a physician or designated health care provider regarding the significance of a positive antibody test. They shall be advised

as to the mode of transmission of this virus, the appropriate precautions and personal hygiene measures required to minimize transmission through sexual activities and/or intimate contact with blood or blood products, and of the need to advise any past sexual partners of their infection. Women shall be advised of the risk of perinatal transmission during past, current and future pregnancies. The beneficiary shall be informed that he or she is ineligible to donate blood and shall be placed on a permanent donor deferral list.

(2) Epidemiological investigation shall attempt to determine potential contacts of the patient with serologic or other laboratory or clinical evidence of HIV infection. The patient shall be informed of the importance of case-contact notification to interrupt disease transmission and shall be informed that contacts will be advised of their potential exposure to HIV. Individuals at risk of infection include sexual contacts (male and female), children born to infected mothers, recipients of blood or blood products, organs, tissues, or sperm, and users of contaminated intravenous drug paraphernalia. Those individuals determined to be at risk who are identified and who are eligible for health care in the military medical system shall be notified. Military members identified to be at risk shall be counseled and tested for serologic evidence of HIV infection. Other beneficiaries, such as retirees and family members, identified to be at risk shall be informed of their risk and offered serologic testing, clinical evaluation, and counseling. The names of individuals identified to be at risk who are not eligible for military health care shall be provided to local civilian health authorities unless prohibited by the appropriate State or host nation civilian health authority. Anonymity of the HIV index case shall be maintained unless reporting is required under paragraph 5.b.

(b) Communicable disease reporting procedures of civil authorities shall be followed to the extent consistent with this memorandum through liaison between the military public health jurisdiction and the appropriate local, State, territorial, Federal, or host-nation health jurisdiction.

Chairman CRANSTON. What plans does the department have for the distribution of the Surgeon General's Report on AIDS to service persons and civilian personnel?

Dr. CLINTON. The written testimony provides some reference to that. We have already distributed several thousand and have ordered several thousand more. More importantly, we have also developed materials that are complementary to that same message in various forms in all three services. We are spending literally hundreds of thousands of dollars on various information materials directed to the community and directed to the individual. Included in that is Surgeon General Koop's message.

Chairman CRANSTON. On page 11 in your testimony, you state that policies involving screening of the family members of military personnel and civilian employees, prior to being sent overseas under military sponsorship, will be developed as necessary by the Assistant Secretary of Defense for Management and Personnel. Is that policy for mandatory testing for family members and civilian employees, prior to being sent overseas, now under consideration?

Dr. CLINTON. There are those who have raised it. That was a more active debate, I would say, several months ago than it is today. There are no immediate plans to do anything. There are those who believe it is the right thing to do—similarly to what we hear along the lines of mandatory testing in the United States. I don't think sufficient rationale has been developed. It certainly hasn't even come to my attention yet—for a definitive statement.

Chairman CRANSTON. What are active duty personnel specifically told with respect to the use of condoms?

Dr. CLINTON. They are told that it minimizes their risk, if they choose to have sex. They are told that abstinence is also useful to stem the spread of the disease. More specific to your point, we are not using the term "safe sex." We are saying it minimizes risk, if they continue to have sexual contact.

Chairman **Cranston**. Why are condoms not now being sold at military commissaries?

Dr. **Clinton**. Because they are widely available in other sources, such as the exchange.

Chairman **Cranston**. Don't you think we should be doing everything possible to make them available?

Dr. **Clinton**. Yes, and that is under consideration. I think commissary systems are constrained to sell only so many products, and it means something else will come off the shelf. Commissaries are there to provide predominantly food products, as you well know. I understand that that is being discussed; I have not yet seen them in the commissary.

Chairman **Cranston**. Is there any discussion of dispensing condoms without charge?

Dr. **Clinton**. No serious discussion.

Chairman **Cranston**. Would you report back on what discussions are going on?

Dr. **Clinton**. I am not aware of any. I hear a whole lot of talk, but there have not been any formal discussions.

Chairman **Cranston**. On the commissary business?

Dr. **Clinton**. I will provide that.

Chairman **Cranston**. Thank you.

[Subsequently, Dr. Clinton furnished the following information:]

We stock prophylactics in military exchanges, but not in commissaries. The DoD Resale Executive Board, composed of the Services' Exchange and Commissary Commanders and representatives of the Office of the Secretary of Defense meets several times each year. At these meetings, general stockage policy is a frequent agenda item. At the meeting in April 1987, the specific issue of stocking prophylactics in commissaries was discussed at length. The DoD Resale Executive Board decided to continue current stockage policy. The rationale for the Board's decision was that the need to have this product available on military bases was being met by the exchanges. The Resale Executive Board pays close attention to the balance of products sold in commissaries and exchanges, which has been carefully developed based on the different missions of the two resale activities.

Chairman **Cranston**. Colonel Bancroft, in the Defense Department's testimony, you indicate that $37.8 million was appropriated in fiscal year 1986 for AIDS research, and $21.8 million for fiscal year 1987. At a time when the research budget for AIDS is increasing at NIH, why did the President's budget include only $5 million for DOD AIDS research for fiscal year 1988?

Colonel **Bancroft**. I have asked the same question myself. I think that it is insufficient, but the first two appropriations—the fiscal year 1986 and the fiscal year 1987 appropriations—were supplemental appropriations. And they came to us late in the fiscal year. For instance, the fiscal year 1986 money came to us in August of 1986; the fiscal year 1987 money is coming to us in June—this month—for use, which we do have permission to obligate this money over the second year. But it still curtails the period of time in which we would ordinarily be able to utilize the money, and it takes a little longer to establish a new research program than it does to commit money and obligate money for an established research program.

At this point, the DOD HIV research effort is still in the beginning stages. Nevertheless, of the fiscal year 1986 money, essentially all of that has been obligated already; and the fiscal year 1987 money is well planned. For fiscal years 1988 and 1989, we are in the DOD budget; and as you say, we are programmed to have $5 million for fiscal year 1988, which I assume will then come with the rest of our research money toward the beginning of the fiscal year and will get us into a more regular fiscal policy.

Chairman CRANSTON. Is there any effort under way to get a more adequate amount?

Colonel BANCROFT. We have sought additional funding. The most difficult year will be for fiscal year 1989, when we only have $12 million for the program. Much of our fiscal year 1986 money has gone to extramural contracts. In fact, almost $30 million of it has gone on to extramural contracts.

In many of these cases, the contracts can be funded for up to 3 years. Those will come up for renewal in 1989, at a time when we only are going to be or are already underfunded.

Chairman CRANSTON. Colonel, out of that total of nearly $60 million combined for AIDS research funded by the Army for fiscal years 1986 and 1987, only $2.4 million has gone to VA researchers. Given the number of AIDS patients being treated by the VA, the VA's relationship to a national defense mission, and the VA's great potential for cooperative research programs, wouldn't it be beneficial from the standpoint of finding more effective treatments and possibly a vaccine to increase the research collaboration between the VA and the Army?

Colonel BANCROFT. We certainly are looking for any opportunity to expand the research cooperation between the VA and the Army. As with all the other extramural contracts and grants, these are submitted to us for scientific review and are judged on scientific merit. The two awarded contracts were considered highly meritorious, and they are certainly program-relevant. They are relevant to the goals of our research program.

Chairman CRANSTON. I just have, finally, a few questions on a topic we have not yet discussed this morning: confidentiality rules regarding partners. In the case of a hospital or clinic—Dr. Curran this question is for you—where a patient tests positive and is symptom-free, do you believe that it would be helpful from the standpoint of confidentiality not to include the test result in the patient's medical record?

Dr. CURRAN. I think that is a tough one; that is why you asked it. I think, under an ideal circumstance, it is important for all medical personnel with a need to know, to know that the patient is HIV positive. And in many hospitals where you don't have a private physician—and I think the VA system would probably fit into that—a person may see a different doctor the next time they come in. They also may see a different doctor in a different service. Having HIV infection is very important and having your doctor know it is important.

So, I think that many physicians, nurses, and others will need to know that a person is infected with HIV. On the other hand, there are liability issues as well as confidentiality issues for the hospital and doctors involved. I think that this is a real policy matter, when it comes to maybe setting up a separate system for HIV results, with some sort of theoretically secret flag that indicates someone should check the separate system out. However, all that usually becomes known by too many people.

I think we could ask DOD. DOD has done this; how did they handle this? It is a tough one.

Chairman Cranston. Do you have a comment?

Dr. Clinton. We believe it should be in the medical record.

Chairman Cranston. John, what is your feeling? There is the question obviously of confidentiality.

Dr. Gronvall. My general feeling is that this is highly important medical information that should be in the record, that we should protect the confidentiality of those records; but the reason for my making that statement is that, if the individual is in fact infected, I would hope that our team of health care professionals working with the patient—and that includes doctors, nurses, counselors, social workers, chaplains, et cetera—would be able to assist the veteran in understanding that a change of behavior or working with the veteran's spouse or contacts is important, so that we get the maximum patient cooperation in doing whatever can be done to deal with the problem that exists.

So, I believe it is relevant medical information. I surely am extremely concerned about the problem that occurs when information leaks. And in fact, one of my very great concerns is that, under existing circumstances, we can and in fact do disclose medical information to insurance companies which they require in order to validate the bills that we submit to collect for care of veterans, as authorized by current law. And this raises a real dilemma for us of disclosing to a third party, reimbursement, or insurance company such highly sensitive medical information.

I would echo Dr. Curran's comment that this is a very tough question. There is no easy answer, and I have tried to portray an objective of medical care; but it surely is not a simple question.

Chairman Cranston. Dr. Curran, if I may ask you this question? What procedures do you consider to be appropriate for notifying spouses and/or steady sex partners?

Dr. Curran. With many other sexually transmitted infections, people who are counseled often choose to notify their own spouses; and I mention this first because the question usually comes up: What do you do in the cases where that doesn't happen? But we have to emphasize that often this works. People bring their own spouses or steady sex partners in for counseling and testing. I think this needs to be exploited and used as much as possible. It takes fewer resources and is more humanistic.

Second, many people prefer that public health representatives or medical representatives inform their spouses; and that is sort of the second approach taken in many public health departments. The patient will say: here is the name; please help me. Now, that is a little bit of a problem for nonsteady partners because that could be misused by people; and it involves the voluntary nature of the informant, if you will—the person who is infected.

There are selected circumstances when the patient may not want the spouse to know. Then the doctor or the public health person will be in a dilemma; and they may be in a legal dilemma. Dr.

Myers, one of your later witnesses, and I were discussing this the other day—what we personally feel.

A man comes in and he is positive for HIV. He says: I don't want my wife to know; she will divorce me and I will lose my job, and it will ruin my standing in the community. What do you do? Well, there may be a law in some States that says you can't release this information; otherwise, you will go to jail. There may be another law that says if you don't tell the person, then you go to jail. So, the doctor knows first of all that he might end up in jail. So, you are back to what do you think ought to be done ethically? And I personally think that the doctor ought to call the spouse.

Chairman **CRANSTON**. John, does the VA have any policies or do you have any views on that?

Dr. **GRONVALL**. We have both policies, and I have views. [Laughter.]

Dr. **CURRAN**. Are they the same?

Dr. **GRONVALL**. And they generally are the same. [Laughter.]

I would align myself with virtually everything Dr. Curran said. I would emphasize the very difficult nature of that dilemma. Our current policy, I think, is very clear. We work with the patient and we only inform either the spouse or anyone else about the existence of AIDS infection or AIDS when we have the patient's consent to do so. That policy for AIDS is the same as our policy for any other disease or other medical problem that a veteran patient has. In most cases, of course, we gain the cooperation of the veteran—in this case with AIDS—and that is the purpose of what I have been describing as the need to work collaboratively and cooperatively with an ill individual, to gain that person's trust and confidence, and to allow us to work with that veteran to inform the spouse or other sex partner so that they can take appropriate steps to protect themselves. But in that very unusual test case, and I am sure we will be tested—in fact, are being occasionally tested—our policy is quite clear. If we do not have consent from the veteran to inform anyone else of the nature of the individual's medical problem, we do not carry that out.

Chairman **CRANSTON**. Yes, Dr. Curran?

Dr. **CURRAN**. I think the clearest and easiest way to see this issue is how the National Hemophilia Foundation and hemophilia treatment centers have dealt with this problem. They have a substantial portion of their constituents infected with the virus, all men, and many of whom are married or have steady sex partners. Over a period of time of quite intensive education and counseling and concern about AIDS, they have moved along—over the 2 years since the test has been licensed—to a policy of recommending routine voluntary testing and counseling of all of the family members.

That is something that is quite a traumatic experience. It is easiest to think of this in the context of the family unit; but most people who talk about this issue are talking about it in other contexts. In the families of hemophiliacs, there is no question about how the hemophiliac became infected. So, it becomes even more difficult when there is a concern about the behavior of the person or hidden homosexuality or drug abuse.

Dr. **GRONVALL**. I would add, if I might, Mr. Chairman, that Dr. Curran stated he has an ethical belief as a physician that the physician should inform the spouse. I agree with that as an individual physician. My comments, though, are in the perspective of a health-care system which is, in fact, an arm of the Federal Government and where policy and procedure have to be tested against the other implications of having an official Federal policy or procedure.

So, as I said, at the present time, our policy is quite clear that, in the absence of consent, we don't make such disclosures in any case about veterans other than under a very clearly defined condition such as a request from this committee, duly established requests for such information.

Chairman **Cranston**. I want to thank you all very, very much. You have been very patient and very responsive. You have been very, very helpful, and I am deeply grateful to you.

Dr. **Gronvall**. Thank you very much.

Chairman **Cranston**. We will now go to the public health panel, consisting of Ms. Mary Foley, San Francisco, Chairman of the Cabinet on Economic and General Welfare for the American Nurse's Association, accompanied by Thomas Nickels, Director of Congressional and Agency Relations, and Ms. Donna Richardson, Assistant Director of Congressional and Agency Relations. Other members of the panel are Dr. Woodrow Myers, Jr., Indianapolis, Indiana State Health Commissioner and President of the Association of State and Territorial Health Officials; Ms. Ann E. McFarren, Executive Director, AIDS Action Council; and Dr. Paul Schafer, Executive Director, National Association of VA Physicians.

We will start with Mary Foley. And Mary, I want to thank you for coming so far and welcome. If you would start, I would appreciate it.

STATEMENT OF MARY E. FOLEY, CHAIRMAN, CABINET ON ECONOMIC AND GENERAL WELFARE, AMERICAN NURSES' ASSOCIATION, ACCOMPANIED BY THOMAS NICKELS, DIRECTOR, CONGRESSIONAL AND AGENCY RELATIONS; AND DONNA RICHARDSON, ASSISTANT DIRECTOR, CONGRESSIONAL AND AGENCY RELATIONS

Ms. **Foley**. Thank you, Mr. Chairman. As you indicated, I am accompanied today by Tom Nickels and Donna Richardson from the American Nurses' Association staff. I am a registered nurse employed as a staff nurse at St. Frances Memorial Hospital in San Francisco. On behalf of the 188,000 members of the American Nurses' Association and its 53 constituent State nurses' associations, thank you for this opportunity to address the Veterans' Administration AIDS policy. ANA has 24 collective bargaining units in VA hospitals in long-term care facilities. There are 35,000 RNs and 32,000 other nursing personnel in the VA.

In essence, the American Nurses' Association believes that the most effective tools for preventing the transmission of AIDS are education and preventive health techniques. We oppose discrimination against persons with AIDS or a positive HIV. We support the availability of quality, confidential health care and respect for the affected individual, and we support increased funding for research and educational efforts. ANA has stated that all people who have AIDS have a right to equitable and humanistic health care, including quality treatment which include nursing and social service support, the nondiscriminatory use of current isolation procedures, full explanations of research procedures, treatments, and risks involved, informed choice of treatment and research modalities, confidentiality of the medical records, and respect for privacy in significant relationships.

As we all know, presently there is no cure for AIDS, but it does respond to care. It is a disease that is nursing intensive. It is nurses who provide continuous care during the hospitalization, in the home, and in the hospice settings. Nursing has had a tradition of providing quality care to the victims of once fatal infectious diseases, such as poliomyelitis, yellow fever, and tuberculosis.

The nursing profession will take a leadership role in continuing to provide safe and effective care to victims with AIDS, their families, and their friends. ANA has recognized that education about the epidemiological aspects of the disease is not enough. The association participated in the revision of the CDC's "Recommendations for Preventing Transmission of Infection with HTLV 3 Virus in the Workplace" issued in 1985. We have repeatedly urged OSHA to address the hazards of AIDS and hepatitis, and since 1984, urged the NIOSH to release its document, which includes recommendations on employee exposure to AIDS. CDC has revealed that three health-care workers, including a nurse, have sero-converted after exposure to blood and body fluids of patients, subsequently revealed to be seropositive for AIDS.

ANA reaffirms its support of the CDC guidelines but believes agency enforcement is necessary to ensure employer and employee compliance. Recently, there has been an increased call for mandatory testing for AIDS by some legislators and the President, who recommended patients who receive care from the VA be tested. Although ANA agrees with the President's admonishment that those with AIDS not suffer discrimination, we differ with his recommendations on testing of hospital patients. In fact, we are more closely in agreement with Dr. Koop, who is quoted:

> Compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who test negatively might actually be positive due to recent exposure to the AIDS virus and give a false sense of security to the individual and his or her sexual partners concerning necessary protective behavior.

The epidemiological benefits of testing do not support the redirection of resources from research and education to test a large body of people who are not high risk. Mandatory testing raises several concerns: First, costs for hospital patients alone have been estimated above $100 million. Second, the feasibility of providing the recommended counseling. Third, the issues regarding positive prenatal test results affecting birthing decisions. And last, the paramount concern of confidentiality of test results.

The latter issue raises particular concerns about discrimination in the areas of insurance, housing, and employment. Additionally, the result of testing all VA patients is that a multitude of documentation must be maintained, making the agency and the individuals vulnerable.

We have already heard a report that a list of the AIDS patients tested for HIV virus was found in an accessible copier after it was inadvertently left by someone hopefully performing official VA business. We shudder to think what the effect of the unofficial release of such information could have on a veteran's employment, housing, or insurance.

The VA is presently experiencing shortages of health-care personnel, and the testing and counseling of all veterans tested will additionally tax these resources. ANA urges the VA to use its resources for AIDS research and staff education and training. Caregivers to AIDS patients will need counselors to combat stress, burnout, and fear. Adequate staff will be necessary to guarantee quality nursing care but also to assure that nurses have the time and resources to comply with the CDC guidelines.

We would also like to take this opportunity to call for a national commission on AIDS with effective development and implementation authority. ANA did support S. 63 and urged that the VA be included in the legislative commission. ANA's June 1987 House of Delegates unanimously adopted a resolution on testing, which is included in our written statement. Most importantly, in summary, it does call for no universal mandatory testing and for informed voluntary testing and counseling, additional research, and a commitment to the rights of AIDS patients.

ANA pledges to continue its role in the community and the profession in promoting AIDS prevention and education. We hope that these hearings will result in a logical, scientifically based VA health policy on AIDS.

Chairman **Cranston**. Thank you very much.

Ms. **Foley**. Thank you.

Chairman **Cranston**. Dr. Myers.

[The prepared statement of Ms. Foley appears on p. 153.]

STATEMENT OF DR. WOODROW A. MYERS, JR., STATE HEALTH COMMISSIONER, STATE OF INDIANA, AND PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Dr. **Myers**. Thank you very much, Senator. I am Woodrow A. Myers, Jr., a physician and the State Health Commissioner of the State of Indiana. I appear before you today in my capacity as President of the Association of State and Territorial Health Officials. Our association is comprised of the chief health officials of the 50 United States, the District of Columbia, and the U.S. Territories. As State health officials, we hold leadership roles in public health in our respective States, both within the medical community and with our primary constituents, the citizens of our States.

Our association has worked closely with the CDC since the first days of the AIDS epidemic, and there continues to be a free, open, and frequent exchange of information and ideas between our association and the CDC. We have provided testimony before Senate committees and those of the House of Representatives on numerous occasions and are pleased to do so today.

There are several questions that I would like to summarize in my testimony. First, should the Veterans' Administration hospitals test entering inpatients and outpatients for the presence of human immunodeficiency virus antibody? Our association believes the answer is yes but with important caveats. First of all, we believe that testing and counseling are inextricably interwoven. And I am confident that our officials in VA hospitals are quite aware of that importance, and we have heard testimony to that effect today.

Our association also believes that counseling and testing are not necessary for every patient in the VA system. We know a great deal about the demographics of this disease and the behaviors that put individuals at risk. Cost effectiveness would be enhanced by physicians' selection of those outpatients and inpatients who fit the demographic profile of a seropositive patient or who, in history taking, admit to behaviors that put them at risk.

For instance, the World War II veteran admitted for multiple episodes of congestive heart failure—a typical VA admission—need not be counseled and tested unless specific behavior has put him or her at risk or blood transfusion occurred prior to the start of antibody testing protocols in our blood banks. Similarly, we do not believe that a patient who is tested and counseled at one point in time needs to be tested and counseled at every single contact point with the hospital in the future. The patient's risk status should be reassessed and, if retesting or additional counseling are indicated, they should be provided as necessary.

Should patients in the VA system have an option for refusing HIV testing and counseling, even when clearly indicated? In the United States thus far, we have held to the premise that an individual has the right to be informed of the care that they can and should receive and that an individual has a right to refuse such care.

The question is whether or not the HIV epidemic warrants a change in that philosophy. Our association believes that a modification, rather than a wholesale change, of that philosophy is indicated. Most physicians feel strongly that HIV testing and counseling needs to be effectively integrated into our normal, regular system of health care.

When we design systems and approaches that isolate HIV related disease from other diseases, inefficiencies and distortions occur. For instance, I am not aware of any hospital that requires a separate written informed consent form for VDRL, a blood test that determines syphilis, for the detection of the organism that causes gonnorhea, or for the detection of the presence of hepatitis B surface antigen.

With each of these diseases, there can be associated societal or informant related stigma, albeit less severe than that affecting the AIDS patient. Yet there has been no cry for a separate document or statement that patients have been informed of these tests and that these tests will be done and that they have accepted the risk of having those tests performed. In some hospitals, procedures akin to surgery, such as insertion of catheters into the heart, procedures with a degree of medical risk that far exceeds the medical risk involved in the collection of a tube of blood to determine HIV status are performed without a separate consent form being obtained.

The primary reason for informed consent is for the patient to understand the risk associated with a given medical act. There is virtually no medical risk from the collection of a sample of blood to determine HIV status. Therefore, those of us who are proponents of informed consent for HIV are in essence telling our patients that some members of our society may act on the information surrounding their HIV status; and our system of confidentiality may not be sufficient to protect them from such action.

As members of the committee may be aware, several States have passed statutes mandating that patients sign explicit informal consent forms prior to the collection of blood for HIV antibody testing. It is the concensus of our association that, given the perceived shortfalls in our systems of confidentiality and given the real threat in some States of individuals losing employment, housing, and insurance coverage, that an explicit right of refusal for HIV testing and counseling should be a part of any testing program base, either in the Veterans' Administration hospitals or in other hospitals or clinics. As a physician, I must tell you that it bothers me a great deal that my colleagues in public health must take a position like this in 1987, a position that says in effect we cannot trust the system to treat patients with this disease with the humanity and the compassion that other patients receive and that all patients deserve.

There are other aspects to our testimony that are within the written portion, and I would be happy to answer questions when appropriate.

Chairman CRANSTON. Thank you very much. Ms. McFarren?

[The prepared statement of Dr. Myers appears on p. 166.]

STATEMENT OF ANN E. McFARREN, EXECUTIVE DIRECTOR, AIDS ACTION COUNCIL

Ms. McFARREN. Thank you, Mr. Chairman. I am Ann McFarren, and I am Executive Director of the AIDS Action Council. The Council represents over 300 community service organizations around the country.

I would like to focus my time with you on discussing the unique role that service providers around the country have offered in terms of managing this epidemic. We know that we now have over 36,000 cases of AIDS and that by 1991 we will be in the range of 270,000 cases. Before there was much attention either at the Federal level or in many states or cities, service providers identified serious problems and lack of health-care services and support as people confronted this terrible illness. As a result, new services and new types of programs were set up in order to provide support to people as they became ill in greater and greater numbers.

We have, for example, in San Francisco a program that includes an education component where the major educational efforts regarding the transmission of the disease and protection of the disease are actively pursued throughout the community. A second organization, working in conjunction with the educational programs, has been established to provide support services and some housekeeping services to individuals with aids and their loved ones.

These programs have been very helpful with a disease that is so devastating and in cases where there are so many, many needs for individuals. For instance, buddy programs are particularly useful in terms of providing ongoing support to people who are devastated by their diagnosis and their illness. In addition to that, the hospice programs that have been set up have been providing people with an opportunity to receive many health-care services and support on an outpatient basis in an environment that is much more pleasant and comfortable than many of the health-care environments that we would otherwise find ourselves in.

These types of programs will probably need to be replicated in many of our health-care environments, including the VA environment. We would hope and recommend that the VA and other organizations that will be providing health care services will carefully look at this type of support mechanism in terms of helping patients and maintaining as much cost effectiveness as we can, as we provide for these very, very ill patients.

These organizations have also provided education programs, and I am distressed that we have heard so little about education because I believe the VA system has an excellent opportunity to rapidly enhance the desperate need for education. A recent study that I read indicated that 40 percent of the population does not know how the HIV virus is transmitted. If they think it is from sneezing, we have a serious problem. If they don't know that it is from sex or from other high risk behaviors, we have a serious problem.

As we learn more about the disease, education of the general public is very important. With all of the inpatient and outpatient transactions in the VA system, there is an opportunity for extensive education, which we all must support and become involved in.

I have brought with me today some educational materials that we think are particularly useful, and I will give them to you for part of the record.

The Council is also concerned about testing. We have heard of the terrible discrimination problems which occur and many of the people that we have worked with have had those types of experiences. We do believe that informed consent must include the social ramifications, emotional ramifications of testing prior to individuals making the decision to be tested. We strongly recommend that there be antidiscrimination legislation before we promote a much more extensive testing program.

I hope this information is helpful, and I am available for questioning.

Chairman **CRANSTON**. It is helpful, and I thank you very much. Dr. Schafer?

[The prepared statement of Ms. McFarren appears on p. 177.]

[The educational materials are retained in the committee files.]

STATEMENT OF DR. PAUL W. SCHAFER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. **SCHAFER**. It is a pleasure to be here to testify this morning. As you know, I am a full-time VA physician, a surgeon, the Chief of Chest Surgery here at the Washington, D.C. VA Medical Center; and I am also the Executive Director of the National Association of VA Physicians, otherwise known as NAVAP. And I speak today in that latter, strictly unofficial capacity.

There has been so much information revealed here in the course of the hearing this morning that I will restrict my remarks to just a part of my testimony, which has been submitted and which I hope you will include in the record.

Chairman Cranston. Yes, it will go in the record.

Dr. Schafer. The NAVAP Board of Directors has recently reviewed its previously published position on AIDS and that, too, is submitted for the record. We are now more than ever appalled by the words and actions of those would fan the flames of the epidemic of fear and hysteria that could occur about this emotion-charged disease. Though much needs to be learned about the disease, as you know there is no scientific basis for yellow gloves to be worn by police handling street demonstrators or by court bailiffs at arraignment proceedings.

It is hoped that the 1988 elections will not become a field day for some demogogues who would make the yellow glove a campaign symbol. We call on the veterans' service organizations and others to join with us in protest of President Reagan's inclusion of the Nation's veteran patients in his recent remarks about HIV antibody testing of prison inmates and aliens seeking to enter our country.

The agency must not promote policies or actions throughout the system implementing such practices for our patients and the health-care workers who serve them. AIDS is an infectious disease for which the profession has well-established procedures for management of afflicted patients and the workers who do care for them. We strongly urge strict observance of the Centers for Disease Control guidelines concerning precautions that should be taken in dealing with blood or body fluids in which the AIDS virus might be transmitted, precautions that are already taken in dealing with other infectious diseases such as hepatitis B.

Surgical teams practicing aseptic technique to prevent infection of patients are at one and the same time protected from AIDS patients upon whom they operate. Viruses, bacteria, fungi, and parasites opportunistically infect the lungs of immunosuppressed patients. Such life-threatening infections can be very difficult to diagnose. I regularly operate on such patients to obtain lung tissues for biopsies that permit accurate diagnosis, often leading to lifesaving specific treatments.

NAVAP is strongly opposed to compulsory mass screening of VA patients and health-care workers. HIV antibody testing should be performed only when the professional-clinical indications justify that the test should be made, and no such test should be made without specific informed consent.

Much evidence exists that lowering of high-risk behavior results from education and counseling in connection with tests, rather than with the specific results of the testing itself. NAVAP encourages the development of effective educational and counseling procedures as opposed to compulsory testing which will scare away high-risk groups from seeking medical care. Available VA funds should be expended for education, counseling, and research, not mass testing. The testing of all VA patients will cost a very substantial amount.

In summary, the National Association of VA Physicians is opposed to compulsory mass HIV antibody testing. Such tests should specifically and professionally be indicated and should be performed only with specific informed consent. The VA should expend its funds on high quality education, counseling, research, and patient care, and on the confidential testing of those who wish it. The VA should develop an active and aggressive education campaign for all VA employees from physicians to janitors, which should include decreasing risk of exposure and an understanding of the social and psychological consequences of positivity.

Finally, this is no time for hysterical fear. AIDS is a serious problem for American society and its only present hope for containment is education. Fortunately, it still remains a very difficult disease to catch. Thank you, sir.

Chairman **Cranston**. Thank you very much.

[The prepared statement of Dr. Schafer appears on p. 186.]

Chairman **Cranston**. I am going to have very brief questions for each of you. First, Ms. Foley, I think it is very significant that, as the representative of nurses, you have testified against mandatory testing of hospital patients and testing only with informed consent. Can you tell us how you reached that position and the extent to which you have a concensus among your members on this?

Ms. **Foley**. Yes, sir. The decision was reached at our June House of Delegates meeting, but that was the culmination of many of the structural units of the American Nurses' Association and the constituent State nurses' associations deliberating in the last year. There have been three cabinets, our Human Rights Cabinet, our Ethics Cabinet, and the Cabinet on Economic and General Welfare, which have dealt with the issue of workplace policies for AIDS testing and the care of the AIDS patient. And in action on their reports, our Board of Directors did produce a statement in June which was amended by the membership in attendance at the House of Delegates; those members numbered 598 at the time of the vote and are reflective of the members throughout the country.

And I believe it was with a great amount of discussion and education that our membership did come to the conclusion that testing would not provide the security. What in fact really provides security in providing nursing care is just using the prescribed precautions and dealing in advance with the knowledge of what the modes of transmission are. Our main enemy has been fear and misinformation, and we have had some very tremendous educational programs. And I do have a pamphlet to share with the committee from the California Nurses' Association. We have conducted programs throughout the State, some with support of State funding.

Chairman **Cranston**. Was there a broad concensus?

Ms. **Foley**. It was unanimous, sir.

Chairman **Cranston**. It was unanimous?

Ms. **Foley**. Yes, it was. We were very pleased with that. I think it reflects very good decision-making on behalf of nurses, who are the direct care givers.

Chairman **Cranston**. CDC has issued guidelines regarding precautions that the health-care workers should take to avoid exposure to HIV. Do you believe those guidelines are adequate to prevent transmission in health-care settings?

Ms. **Foley**. Yes, we do. We endorsed those guidelines last year and then also endorsed them after the discussion on the invasive procedures. We feel that they do provide adequate protection. We have used them consistently with the hepatitis B; and because of the similarity in the modes of transmission, it is appropriate. I think Dr. Curran's comments about the addition of goggles and masks will probably be additional procedures for invasive procedures or where there is the opportunity for splashing of body fluids.

I myself have changed my own practice habits. I administer blood two or three times a week, and I also take care of a mixed population, somewhat with an elderly population who we would assume would not be at risk but, in fact, because of orthopedic surgery, many of these patients have received blood transfusions, and a few have become infected. I have just changed my behavior, as have most of the people I work with. Those who are educated are still providing excellent care, humane care.

You don't wear gloves when you give your tablets or your back rub, but you do wear gloves when it is body fluid exposure. And we have been able to balance it. I think there will still be some fear, and there will be individuals who are reluctant to care for the patients in the most humane way. I think education will be our greatest opportunity.

Chairman CRANSTON. Thank you very, very much.

Ms. FOLEY. Thank you.

Chairman CRANSTON. Ms. McFarren, I was pleased to hear your call for the VA medical system to initiate a sweeping educational campaign. As you know, I agree completely. What, in essence, do you think should be included in that campaign?

Ms. MCFARREN. It certainly should include information regarding the transmission of the disease and how we can protect ourselves. I think one of the things that is very interesting about people who want testing is they seem to think that, if people are tested, then they are protected from the disease. Health care professionals can protect ourselves by simply using sensible actions as we interact as health-care providers or with individuals infected with the AIDS virus. Specific major pieces of information should go to the general public, enough so that they know whether they might be at risk and need additional information.

Availability of additional information needs to be sensitive to cultural needs and individual's personal needs in order to assure that they understand how the disease is transmitted and what they must do in order to avoid transmitting the disease to someone else or avoid receiving the disease from someplace else or someone else.

Chairman CRANSTON. Do you believe, in order to develop the most effective materials, the VA could benefit by having input from community-based organizations that have been developing such educational campaigns?

Ms. MCFARREN. Absolutely. As a matter of fact, I suspect that they would be off target if we did not use those types of groups 'experience in order to expand and use our program.

Chairman CRANSTON. Dr. Gronvall, if you could consult with such groups as you develop your educational campaign, I think that would be helpful.

Dr. GRONVALL. Yes, we certainly will.

Chairman CRANSTON. Good. Dr. Myers, in your prepared testimony, you do not mention two concerns which others often cite as reasons for giving the individual the right to informed voluntary consent to testing: first, the psychological impact of learning that one is infected; and second, the notion that involuntary testing may be counterproductive to the effort to obtain the individual's voluntary cooperation in modifying his or her behavior. What weight do you give to those factors?

Dr. MYERS. I think they are both important, but I would not give them undue weight. I think that testing is clearly something that we must pursue much more vigorously than it has been pursued in the past and that we must, as health-care providers, help to convince our patients that it is important for their personal health and the health of the ones who are around them to get tested.

Now, I think it becomes, Senator, more a matter of how you go about doing it. If you provide a written form for patients where they are forced to read a number of technical paragraphs or that is full of jargon that basically can scare them away, then that is a different situation than sitting down with them and telling them that it is important for their health and that there are some potential risks; and then encouraging them to have the test. So, I am much more in favor of having that personal interaction and much less in favor of having specific documented informed consent forms for the seropositivity test.

Chairman CRANSTON. Thank you very much. Dr. Schafer, I thank you for your very constructive testimony. Do you believe that the confidentiality of medical records that currently exist in the VA system is sufficient to safeguard the protection of test results of the HIV antibody test, especially if testing became widespread and mandatory?

Dr. SCHAFER. I share with Dr. Gronvall this very, real concern; and I am afraid my answer to your question is that I don't believe it is adequate, and I am not exactly certain how it can be made adequate. The medical record obviously contains all sorts of privileged information that should not be treated without full sense of the importance of confidentiality; but the fact is that an awful lot of people see those medical records inside the VA hospital.

We don't have them chained and locked up in a secure fashion. This is a very dynamic, health delivery setting in which many people would have opportunity to see such information if they were curious enough and energetic enough to want to do it. But beyond that, once the record is brought together inside one of our medical administrative services, the fact is that the record is still retrievable under many settings.

Dr. Gronvall mentioned the one that is so very obvious and is a matter of great concern, and that is that it can be retrieved by insurance companies in respect to authorized third-party payment. So, I am concerned about it, and I really don't think that it is as confidential as it should be.

Chairman CRANSTON. If you can develop any recommendations for us as to how to make it more secure, we would certainly like to have them. If you could submit your thoughts in writing on that, it would be helpful.

Dr. SCHAFER. We will be glad to do that.

[Subsequently, Dr. Schafer furnished the following information:]

It is our intention to explore the possibility that the Agency's Decentralized Hospital Computer Program (DHCP) can be programmed for secure treatment of HIV antibody test results.

Chairman **Cranston**. Under what circumstances would you encourage a patient to have the test done?

Dr. **Schafer**. I mentioned in my oral testimony that there certainly are well-established professional-clinical indications for one to want to know about HIV positivity. Of course, all of those circumstances would be occasions when one would want to talk with the patient and convince him/her of the importance that this has in respect to their and our understanding of their disease and the potential for treating them and treating them correctly.

Now, as you get to the less clear circumstance of wanting to know about HIV antibody positivity in a nonclinical and nonprofessional indicated setting, I don't have good and clear answers to present to you about that. As you noted in my prepared testimony, I am very much concerned about all of the adversities that would attend mass screening; and among those, of course, is the horrendous problem posed by false positivity.

Chairman **Cranston**. I thank each of you very much for being with us. I thank you again particularly for coming all the way across the country. Thank you very much.

Now, we will go to our final panel of Veterans' Administration field staff, consisting of Dr. W.A. Crow III, Houston, Texas, Associate Chief of Staff for Ambulatory Services, Houston VA Medical Center; Dr. Earl Gordon, Los Angeles, California, Chief of Staff of West Los Angeles VA Medical Center; and Dr. Michael Simberkoff, New York City, Chief, Infectious Disease Section, New York City VA Medical Center.

I thank each of you for traveling to be with us this morning. Dr. Gordon, I particularly thank you for coming so far, as I thanked one of the previous witnesses.

Dr. **Gordon**. Thank you.

Chairman **Cranston**. We have invited you here because your medical centers have among the heaviest AIDS caseloads in the VA. In fact, Manhattan and West Los Angeles are the two highest caseloads in the VA. We have a number of questions for you. Unfortunately, I have to leave in just a couple of minutes. So, I will not be able to complete all of them.

I am going to another matter connected with VA medical care. So, our Chief Counsel, Jonathan Steinberg, seated at my left, will pose most of the questions to you. I do want to pose one question before I leave.

What are your personal and professional views on the proposal we have been discussing all morning to test all inpatients for the HIV antibody? Will each of you give a very brief answer? It has to be done in about 2 minutes because I have to leave that fast.

Dr. **Crow**. Senator, I think it has been clear, and I have the opinion as well that routine testing on all VA inpatient admissions is not indicated scientifically, nor do I think it is possible, given our present resources.

I think we need to focus our testing. I think we can focus that testing, and I think routine testing of those focused groups may well be indicated. Those groups could be males between the ages of 20 and 40; maybe they are all presurgical patients, or certainly all patients in identified risk groups. I don't want to comment specifically on what those focus groups would be, only to say that I think that is where our efforts should be—to determine what those focus groups are and move on.

Chairman **Cranston**. Thank you. Dr. Gordon.

Dr. **Gordon**. I, too, Mr. Chairman, would be opposed to mandatory testing. My first concern is that it would keep veteran patients from seeking care in our medical centers, and I don't want to deprive any veteran of the care to which he is entitled. Second, it deprives patients of their right to participate in decisions relative to their health-care delivery. There are other reasons, too, but I think these are the two essential ones that govern my decision.

Chairman **Cranston**. Thank you very much. Dr. Simberkoff?

Dr. **Simberkoff**. Senator, I am also opposed to routine testing. My major concern is the importance of counseling of patients. I think that counseling must be begun before the test is done, and the counseling can start in the process of acquiring the informed consent, which I think is necessary for any test to be successful. I think we must have pre-test counseling, testing, and then post-test counseling, then open our doors—which is the key to dealing with patients if they are positive—tell them that they have a place to come for medical care and evaluation. Then, we will have a successful program for dealing with HIV; and without those, we will not.

Chairman **Cranston**. Thank you very much. I thank each and all of you, the witnesses at the table now and others, for their participation in this very productive hearing. Jon Steinberg will now carry on. Thank you very much.

Mr. **Steinberg**. Perhaps if we could backtrack a moment, it would be helpful for the purposes of the record. If each of you, starting with Dr. Crow, would identify your responsibilities in connection with AIDS patients at your medical centers? Dr. Crow?

Dr. **Crow**. I am Associate Chief of Staff for Ambulatory Care in Houston. I have a broad range of activities in that role. However, my role with HIV infected people springs primarily from my position as a staff internist in the Internal Medicine Service in Houston.

I started our AIDS screening program back in 1982 and have been very active in close, hands-on care delivery to these patients.

Mr. **Steinberg**. Dr. Gordon.

Dr. **Gordon**. As Chief of Staff of the Wadsworth Division at VA West Los Angeles, I of course have primary responsibility for the quality of care delivered to our patients and also the responsibility to carry out VA regulations in this regard.

Mr. **Steinberg**. Dr. Simberkoff?

Dr. **Simberkoff**. I am the Chief of the Infectious Diseases Section at the New York VA. Our facility has seen 340 AIDS patients since 1979. That represents about 1 percent of the AIDS cases that have been reported in the United States and about 17 percent of all the cases reported in the VA system.

As Chief of the Infectious Diseases Section, I oversee the care of these patients from the point of view of their infectious problems. All of the patients are referred to the Infectious Disease Clinic following discharge from the hospital, so that all of the individuals with AIDS and all of the individuals known to be HIV positive or to have symptoms suggestive of ARC are also followed in our clinic.

Therefore, the clinical care in and out of the hospital largely falls under my supervision. In addition, I have been involved with clinical research in these areas. I am a co-chairman of the VA Cooperative Study Program, which you have heard described as a program which is supported by the VA Medical Research Department, the VA Cooperative Studies Program, and the Department of Defense. It is a trial which is being conducted of the efficacy of AZT in patients who have AIDS-related complex; and it is currently being carried out in New York, Miami, Houston, West Los Angeles, and San Francisco.

Mr. **Steinberg**. I wonder if each of you could tell us—and we will start with you, Dr. Simberkoff—what policy is followed at each of your medical centers with regard to HIV testing, from the point of pre-test counseling, informed consent, post-test counseling, et cetera?

Dr. **Simberkoff**. Yes. Our hospital has had a policy which required a written informed consent for HIV testing since that test became available in 1985.

Mr. **Steinberg**. Could I interrupt you for one second? Would you please provide us a copy of that informed consent form?

Dr. **Simberkoff**. Yes.

Mr. **Steinberg**. Thank you.

[The consent form appears on p. 190.]

Dr. **Simberkoff**. The consent form describes the test itself, tells the patient its significance in terms of progression to AIDS is not known, that the patient will require further followup if the test is positive, and that the Infectious Disease Clinic will provide that followup for him. And it also informs the patient that the results of the test will be included in his medical record; that the medical record is available to other hospital personnel, but is otherwise considered a confidential hospital document.

We share some of the concerns that have been expressed earlier by Dr. Gronvall and Dr. Schafer about the way those charts are sometimes used. Nonetheless, all of our patients are aware that the results of the tests will be put on the chart if they are positive.

Mr. **Steinberg**. I don't think you covered the pre-test counseling.

Dr. **Simberkoff**. Oh, I am sorry. Counseling is actually begun at the time that the patient is first approached concerning the performance of the test. We explain to the individual, first of all, the nature of the test and also we will discuss the HIV infection itself—the means by which it is transmitted, the possible manifestations of the disease, and that further transmission of the disease may be prevented. Once the test result is available, the patient is again brought in for a personal contact with a physician or an AIDS specialist nurse to discuss the results of the test. The results are not given over the telephone.

Again, we review information about the test itself and its significance, inform the patient that they can be followed in our clinic and should be followed in our clinic if the results are positive, and further counsel them about transmission of the disease and means to prevent further spread of it through sexual encounters or through sharing of blood or donating blood for transfusion.

Mr. **Steinberg**. What do you tell them if they are negative?

Dr. **Simberkoff**. Individuals who have negative tests usually are ecstatic when those results are given to them. We tell them that the result of the test does not mean that they may not become positive at some time in the future, and we then counsel them about ways that they may acquire infection through multiple sexual contacts or sharing of blood or needles through intravenous drug abuse.

Mr. **Steinberg**. Do you tell them indeed that the negative result doesn't indicate that they are not then positive?

Dr. **Simberkoff**. We tell them that the test indicates that there is no evidence of infection that we can detect at that time. Most of these individuals have come to us as a result of past histories of high-risk behavior, either homosexual contacts or intravenous drug abuse. We stress to them that there is a very low but present number of false negative tests, for which we cannot entirely exclude the possibility of the virus being present. We also stress to them the fact that the high-risk behavior which they may have practiced in the past will certainly put them at risk of acquiring infection, should they continue such behavior.

Mr. **Steinberg**. The point is made clear that, just because they have a negative test result, it does not mean they can resume their high-risk behavior?

Dr. **Simberkoff**. Exactly.

Mr. **Steinberg**. Indeed, if they do, they need to be tested again?

Dr. **Simberkoff**. Exactly.

Mr. **Steinberg**. Dr. Gordon.

Dr. **Gordon**. First of all, we limit our HIV testing to those in which there is a clinical indication or suspicion of AIDS related complex or AIDS, although I would hope that we could extend this on a voluntary basis to other members of high-risk groups. We ask our physicians to do a pre-test counseling, as has been previously indicated by Dr. Simberkoff.

And then, we require a written and signed informed consent on every patient.

Mr. **Steinberg**. Would you please share a copy of that with the committee?

Dr. **Gordon**. Yes, I would be happy to.

[The consent form appears on p. 194.]

Mr. **Steinberg**. Thank you.

Dr. GORDON. This signed informed consent goes with the blood specimen to our clinical laboratory. No specimen is sent out to Lexington or to commercial laboratories without the presence of that signed consent in the laboratory.

The specimens are then sent out by code to either Lexington or a commercial laboratory, and we maintain rather strict confidentiality of all test results, which are retained by our chief of our laboratory service. The results are then reported directly—verbally—by the chief of the laboratory service to the primary physician, be the result negative or positive; and then the patient is called in to discuss the results with a physician and counseled. And this, of course, is the most important part of the counseling.

We also ask our physicians that notations of counseling and blood test drawing be recorded in all of the medical records, although at the present time we have kept the printed test results out of our laboratory computer system and out of our medical records.

Mr. STEINBERG. So, at West Los Angeles, the result, positive or negative, of the test is not entered into the medical record?

Dr. GORDON. It has not been up to this time. First of all, as you know, the laws of the State of California, which we try to recognize, enforce strict confidentiality. Second, with our four main clinical units scattered over a large geographical area, I feel uncomfortable about the confidentiality that we would achieve if the tests were put in the medical record at this point in time.

Mr. STEINBERG. Now, if the patient is symptomatic, that is a different matter with respect to what goes into the medical record. Is that correct?

Dr. GORDON. That is correct. The diagnosis of AIDS or AIDS-related complex is plainly documented in the medical record, and this is known to everyone; and certainly, confidentiality at that point is not that important for this group of patients. I must say that our informed consent does permit us to put in the medical record the results of their tests in every case.

Mr. STEINBERG. But if I understand you correctly, the policy is that those test results remain in the laboratory in a central repository?

Dr. GORDON. A locked repository, with access by any health-care provider who has a need to know.

Mr. STEINBERG. Dr. Crow.

Dr. CROW. At Houston, we likewise have an informed consent procedure. We developed that informed consent form in accordance with hospital policy, under which we have been operating now for 2 years, since this test was available.

Let me give you first our old policy and then the new policy that is currently under revision and will probably be approved. In the beginning, we offered the HIV antibody test only to individuals who had a symptom complex that would make the diagnosis of HIV-related disease a likable one, patients identified in high-risk groups.

We would not allow that test to be ordered except over the signature of a staff physician in the Infectious Disease Service or in the General Medicine Service who had some experience in dealing with this disease. The patient was asked to sign an informed consent that specifically related to the patient what he could expect to get from the results of this test, what he couldn't expect to get, what it meant, what it didn't mean, et cetera.

About the first of this year, we realized that the policy was cumbersome. So, we have liberalized that policy now to where the test can be ordered by any staff physician or any staff dentist. We make a very concentrated effort in accordance with CDC guidelines to offer that test to all patients that we identify to be in a known risk group. We offer the test to them, whether they ask for it or not. Obviously, we still utilize the test in the areas where it is clinically indicated, based on the symptom complex. The consent form has remained essentially the same.

Mr. STEINBERG. Will you please provide us with a copy of that form?

Dr. CROW. Yes, I will.

[A copy of the consent form was not available at time of publication.]

Dr. CROW. On the back of the consent form, much like Dr. Simberkoff describes, is a statement whereby the referring physician will readily know to whom he can refer his patient for information if he is not prepared to give that information; and likewise, a specific set of points fashioned after the CDC guidelines and other relevant counseling aspects on a patient who is HIV positive or negative. I think it is inherent in the informed consent process that the patient does get pre-test counseling.

Post-test counseling is carried out by face-to-face contacts. Once again, we don't give results over the phone. Our patients are called in, and they are counseled at that moment, whether they are positive or negative. We make a very strong effort, once again, in high-risk group populations to make them understand that this test is not the be-all and end-all; it means at this point in time there is no detectable evidence of exposure to this virus. But that is all it means.

Mr. STEINBERG. Tony, I have several other questions, but after one more, I will yield to you and then come back.

I might make a comment. It has always been somewhat of a mystery to the committee why, in an instance like this, a system, which is to some extent a centralized medical program, has three informed consent forms that have been developed independently. I am sure each of them is very good and has its own strengths and perhaps weaknesses. Why doesn't the Central Office in a situation like this, provide to medical centers—if not a standard form that each center should use, if it wishes to—a sample form for guidance that medical centers might wish to adapt to their own uses? I am actually addressing this observation to some extent to Dr. Gronvall, Dr. Cohn, and Mr. Lindsey, who are still with us, and I would ask them to give some consideration to that.

But I wonder if any of you would like to comment on that? Dr. Simberkoff?

Dr. SIMBERKOFF. I would just like to make one comment. There is a VA Infectious Disease Advisory Group which met to discuss the issue of AIDS in the VA a couple of years ago. At that time, several of us—including I think representatives from West Los Angeles and several other hospitals—talked about policies that were currently in practice for testing for HIV at the respective medical centers.

And we did distribute, at least among ourselves, copies of the informed consent forms that were being used at that time. I believe that these have been made available to other medical centers upon request, and I think that in some cases they have been either copied or modified appropriately for the purposes of the local hospital.

Mr. **Steinberg**. I think what you are commenting on is this so-called underground railroad, which has always worked.

Dr. **Simberkoff**. Yes.

Mr. **Steinberg**. I guess I am wondering why we can't use the overground route more often. Dr. Gordon.

Dr. **Gordon**. It is my understanding that VA policy does not require a written informed consent.

Mr. **Steinberg**. Yes, I believe that is correct.

Dr. **Gordon**. They do require that a written informed consent be a part of every medical record. It doesn't have to be a form.

Mr. **Steinberg**. Right, and I believe also the current policy is that a notation that informed consent was in fact given should appear in the medical record.

Dr. **Gordon**. In the medical record; that is correct. However, when you tell physicians—and we have a number of residents that rotate through our hospital—you hope that everyone will counsel every patient. I feel that at least we have developed a form that, if the counseling in any way is inadequate, at least I feel safe that the patient has been given a certain basic amount of information.

And this is why we developed our own forms, to meet our own needs at a given facility; and we appreciate this flexibility.

Mr. **Steinberg**. I guess what I would suggest at a minimum—and I noticed that each of you from the field are not calling for Central Office direction—that, without respect to whether or not the Central Office should require a consent form—it does not, as you say at present—it would be appropriate if the Central Office said here is a form that has been adapted from the experience of our medical centers with the largest populations of AIDS patients. Or maybe here are three different forms, and we send them to you in the event that you wish to use them.

It would seem to me that a centralized medical system could at least anticipate the needs of its medical centers and provide that kind of guidance and assistance. Dr. Gronvall has been kind enough to remain with us and also to join us, and he certainly deserves equal time on this issue.

Dr. **Gronvall**. I don't know if Dr. Cohn might want to comment first.

Mr. **Steinberg**. Dr. Cohn, did you want to comment first?

Dr. **Cohn**. Yes, just one thought. The piece of paper, in our minds, is not near as important as the concept for which it stands. I think this point was brought home as late as last week in the conference mentioned earlier in the testimony. It is a concept of informed consent, I think, that makes the difference; and I think guidelines from Central Office have been fairly specific along those lines, that informed consent will be obtained.

The form itself—the piece of paper—I think is individual, and quite frankly, in my mind does not carry near the weight, if you will, that the concept does.

Mr. **Steinberg**. Dr. Grönvall.

Dr. **Gronvall**. If I may, Mr. Steinberg, I should comment that I have had little preparation to respond to criticism that we have provided inadequate amounts of guidance, forms, rules, or requirements to our medical centers. So, as a generalization, I hardly know how to respond to that criticism since it is almost never made.

If I could be serious, I think the comments have been right on target. We have deliberated extensively exactly on that issue, came to the conclusion that there was not either a need for or a requirement for a written consent form to do AIDS testing. I think we have distributed to the field documents that describe again and reinforce the importance of gaining informed consent, and I agree totally with the description that it is the exchange of information and understanding between the physician and the patient that counts in gaining the patient's understanding of what is going on and pre- and post-test counseling is what is critical.

So, we have reinforced the need for informed consent, but wanted to stop short of either prescribing or even really strongly urging the development of a written form. It is clear that information circulates around among our hospitals through the underground railroad and through other informal means and the General Counsel's Office——

Mr. **Steinberg**. And through congressional hearings.

Dr. **Gronvall**. Yes. And the General Counsel's Office has been well aware of this and involved in it; and the fact that some of our individual medical centers have chosen—based on their own unique experience—to develop a written form that helps them achieve informed consent with their patients is something that we view as an appropriate local exercise. I have reviewed the specific forms, in fact, that are being described; and in each, there is additional information that is really unique to that individual institution or to the fact that research studies are going on, and so there is an explanation of the use of this information in a research center setting. That kind of information wouldn't be utilizable across the entire system.

So, I really support the local initiative in this case to develop a form, if that is desired, that is unique to the individual institution and the setting and the patient characteristics, rather than imposition of a form. You didn't call for us to impose a form; so perhaps I am overreacting to the question. So, the only thing additional I would say is that we view our role in the Central Office as providing guidance on the characteristic of informed consent and then leave the local medical staff to work out the best way to accomplish that, that is unique to the individual setting.

Mr. **Steinberg**. As I said, it seems as though each of the local facilities represented here is perfectly comfortable and happy with that degree of discretion. So, I will exercise a lot of restraint and won't pursue this. Tony?

Dr. **Gronvall**. Thank you very much. [Laughter.]

Mr. **Principi**. Thank you, Jonathan, and thank you, gentlemen. I just have a very few questions. Dr. Gronvall's testimony indicates that there is a rather wide disparity in the funding provided to your institutions under the resource allocation methodology. You receive somewhere around $8,000, for the treatment of an AIDS patient when the actual cost of such treatment, with figures ranging anywhere from $24,000 to $38,000. Given the relatively high percentage of AIDS patients in your facilities, how do you deal with that shortfall? Dr. Simberkoff.

Dr. **Simberkoff**. It has been a very difficult problem for the center, and some of the information that Dr. Gronvall alluded to has been developed by each of the participating centers here today. So, I think each of us have had to deal with this problem. Obviously, we are interested in developing better methods for caring for our patients, as well as being reimbursed for them. I think that we all feel—or certainly we in Manhattan feel—that we are reaching a crisis stage in terms of our personnel and facilities available for dealing with the increasing number of patients who are currently recognized as having AIDS or being followed in a hospital or a clinic, those who are being recognized as having AIDS-related complex and perhaps are progressing to AIDS at a greater or not so great rate, and those individuals who are HIV positive but with minimum immunological dysfunction who need to be followed but at less frequent intervals.

We certainly are trying to develop strategies and individuals in the Central Office have been very helpful in assisting us in this—in developing better means of treating these patients in the hospital, out of the hospital in day care centers, and in clinics. And we are hopeful we can develop a unit concept which will improve our ability to treat these patients on an ongoing basis.

Mr. **Principi**. Dr. Gordon, how does it impact on your facility, and does it impact on the non-AIDS population of the facility? By that I mean the fact that you have to reduce your level of services facility-wide.

Dr. **Gordon**. No, we do not reduce the care of other patients. We just manage to get by. And I will tell you that the recent allocation of funding that we received from VA Central Office will be of tremendous help to us, and I think will adequately get us through this fiscal year. It would be very nice, since the resource allocation methodology does not provide us sufficient reimbursement, if we could have funding that we could predict with regularity on an annual basis and, hopefully, maybe the VA budget will permit this in the years to come. From this point forward, I envision a much more serious problem. While I think $20,000 to $25,000 per case is a reasonable approximation of what we would spend, this figure was derived before AZT was implemented.

We just started offering AZT to our patients about 3 months ago, and already we have 22 patients on AZT. These are outside of our cooperative studies. And at the present time, the cost of AZT to our pharmacy, is $8,000 per patient per year, if the patient lives and has the AZT for a full year. And we are going to see more and more of these patients who may qualify for AZT. So, really, you have to now add another $8,000 onto the basic cost of medical care for these patients.

Mr. **Principi**. Thank you, Doctor. Doctor Crow.

Dr. **Crow**. I think the cost of these patients has impacted us in Houston in two primary ways. One is pharmacy cost, and I am not speaking specifically about AZT—certainly that is a major component—but just the cost of the other antimicrobials that these patients often require. So, pharmacy costs will certainly, I think, eat up most of that extra allocation that we recently received, without which I think we would have a very difficult time.

The second area of major impact is the laboratory cost. We recently looked at a series of 20 or so of our AIDS patients in the last fiscal year and found out that we used five times the number of laboratory procedures in the care of these patients than we would in a regular non-AIDS patient.

And a lot of time that laboratory cost is not the routine, cheap CBCs or serum chemistries. It is the more sophisticated viral cultures and other things along those lines. So, it is a very difficult area for us to compensate for the load.

There are movements under way, of which I am aware, in the Central Office to perhaps make the resource allocation methodology a little bit more responsive, you know, to this problem, especially one that is increasing logarithmically, if you will, in incidence.

Mr. **Principi**. Thank you. Dr. Gronvall.

Dr. **Gronvall**. If I may, I appreciate the excellent comments that have been made. We have in fact taken steps to try to come to grips with this issue for the 1988 budget on a regular basis so that we won't be in the position of having to make a special allocation part way through the year.

We have created a task force that is, in fact, chaired by the Director of our Manhattan Hospital because we felt—as Dr. Simberkoff pointed out—that they have had the greatest amount of experience and, in fact, much of our cost information has come from their experience. So, we created the task force, chaired by Mr. Garfunkel, the Director of the Manhattan VA, with other appropriate people; charged them to develop a recommendation, which I expect to receive by mid-July, that will recommend how our initial budget allocation to each medical center for the fiscal year 1988 year, which will start October 1, 1987, can take into account the best informed projection that we have of what the caseload of AIDS patients will be and what the cost of that care will be during 1988, so that we build that into the medical center's budget at the beginning of the year.

Once again, however, although we will do that, we have all testified that it is very hard to predict the future; and unanticipated changes either in the incidence of the disease, the caseload of the disease, or the availability of treatments—which may in themselves be very expensive and increase the cost—those may change during the course of the year. So, I think this is a situation that requires continual monitoring; and that is really why, during this year and last year, we made a special additional allocation to the high-incidence hospitals part way through the year.

While I hope we don't have to do that next year, if there is some change, we will do it again because our goal is to ensure that each of the medical centers with a substantial incidence of AIDS cases has the resources necessary to provide excellent care to those veteran patients.

Mr. **Principi**. Is the cost of AZT coming down, Dr. Gronvall?

Dr. **Gronvall**. I assume that it will as manufacture expands. The drugs have been in very short supply. Back at the time that we got approval to do the controlled study that we have described, the drug was in such short supply that there was question about whether the study could even be mounted. We gained approval, and that really represented, I think, a national decision that this controlled study done in the VA was so critical to this disease that a certain amount of that drug should be allocated for this study.

We are doing the only study of that sort because the drug is in short supply. I have been told recently that other manufacturers are moving into the area and that—and I have forgotten which pharmaceutical manufacturer produces AZT—but the production is being expanded. And I would assume, as is usually the case, that with expanded production, the cost will come down; but I don't think we have seen it yet.

Mr. **Principi**. One further question, John, please?

Mr. **Steinberg**. John, why don't you just remain there for a few moments, if that is all right?

Dr. **Gronvall**. It is fine with me. I am not a witness.

Mr. **Steinberg**. It is fine with the committee.

Dr. **Gronvall**. I will be pleased to answer.

Mr. **Principi**. Could you tell me what is your current AIDS population—diagnosed AIDS population? And perhaps more importantly, what would be your estimates of the number of veterans who are being treated in your facilities for ailments from pneumonia to lymphoma which may be interwoven with AIDS but there has been no diagnosis for the specific HIV or the AIDS? Any ideas along those lines?

Dr. **Simberkoff**. Yes. As you probably know, the criteria for the diagnosis of AIDS are quite strict. We use the criteria which are established by the Centers for Disease Control, and they are themselves in the process of being revised. Copies of the revised criteria have been circulated and were circulated at the Third International Conference. They will probably be formally adopted within the next few months. So, some of the patients that we currently call AIDS-related complex may be reclassified as AIDS, once those criteria are adopted.

We are currently aware of—our total number of AIDS patients is, as I said, 346. Of that group, approximately 200 have died, give or take a couple. So, about 130 to 140 are alive and are being followed in our facilities and clinics. Of that group, 90 percent were diagnosed initially at our hospital. Ten percent came to us from other facilities, some private facilities in the New York City area where patients exhausted their medical insurance and came to the VA only after they were forced to do so because of economic reasons. Some individuals came to us directly from the military service, after being discharged with diagnoses of AIDS. So, that represents about 10 percent of the patient population. In terms of the number of individuals with AIDS-related complex that we are currently following, it is somewhere between 50 and 70 patients. The limit to the number of patients that we can follow is simply the limit of the size of our clinic. They are other individuals who are being followed in medical clinics of whom we are aware, but are not following them. They are being followed by medical residents, and they have diseases which are perhaps thought to be related to HIV; but because diagnosis of AIDS has not been made, they are not yet being followed in our clinic.

Mr. PRINCIPI. Would your treatment methodology change if you knew they were infected with the AIDS virus?

Dr. SIMBERKOFF. At this point, no, becauce the only treatments that are available for individuals are treatments with AZT or treatments with a specific infection that is a consequence of AIDS and for which we already are using established therapies.

Mr. PRINCIPI. It would just be the AZT then?

Dr. SIMBERKOFF. Right. All patients who are thought to be candidates for AZT and who wish to be evaluated for that are screened and followed by our clinic. This is one of the legitimate indications for HIV testing and for determination of immunological status. So, if a person wishes to be considered for AZT, either through the VA cooperative study or through open protocols, then he will be referred to the Infectious Disease Clinic. He will have HIV testing and immunological testing done to determine whether he is eligible for one of these treatment options.

Mr. PRINCIPI. Thank you. Dr. Gordon. Dr. Crow.

Dr. GORDON. Since 1980, we have made a diagnosis of AIDS in 174 patients, an additional 24 AIDS-related complex. At the present time, we will have about 10 AIDS patients or AIDS-related complex patients in the hospital at all times. This contrasts with our experience of about four patients a year ago. We have an AIDS clinic in which we are currently following about 75 patients with AIDS and AIDS-related complex. This last week, I appointed an AIDS coordinator for our hospital, and my next step is to coordinate all AIDS patients into a single, dedicated clinic with a multidisciplinary team approach that I think will enable us to give much better care to these patients in that sort of setting.

Mr. PRINCIPI. Dr. Crow.

Dr. CROW. We have had around 100 cases of AIDS that we have diagnosed in Houston since the onset. That number may be a few more or a few less, depending on exactly which statistics one looks at; that is a fairly round number. We have had 32 new cases since the beginning of this fiscal year. I believe for fiscal year 1986, we had 61 unique social security numbers with AIDS in our patient population.

We are projecting around 120 new for fiscal year 1988 and 1989. One statistic which was surprising to me was that in Harris County, or the metropolitan area of Houston, approximately 1,100 cases of AIDS have been diagnosed since the onset of this disease. We have diagnosed 100 of those; I think to take care of 10 percent of the AIDS population in our metropolitan district is fairly surprising.

We have made an effort in the last 6 months to go back and call back every HIV antibody positive patient that we have had in an effort to try to see where they are. That clinic now is approaching 150, I believe, to 200 patients that are actively being followed.

Mr. PRINCIPI. Thank you. Thank you, Jonathan.

Mr. **Steinberg**. Dr. Gordon and Dr. Simberkoff, do you call back positive test patients as well? Do you have any policies on that, as Dr. Crow just mentioned?

Dr. **Gordon**. We would like to have every patient come back to be told personally the results of their test.

Mr. **Steinberg**. I think that he was talking about follow-up beyond that.

Dr. **Crow**. Yes. What I was actually referring to is patients who, since June 1985 when we started doing this test, have been antibody positive, and who may or may not have been referred to our clinic. We have made an effort to go back and call those people back in, whether they were actively in the health-care system or not.

Mr. **Steinberg**. That is what I am referring to.

Dr. **Gordon**. At the present time, we have had limited staffing in our infection control program due to problems in recruitment of nurses; but this is my goal, and this is why we have appointed an AIDS coordinator because I don't want any patients to slip between the cracks. If they don't come back for their appointments, I want to followup on their status. This is our objective, and I think we will be able to achieve it.

Mr. **Steinberg**. Dr. Simberkoff, do you have any comment on that?

Dr. **Simberkoff**. Yes. We do attempt to follow all the individuals; again, not everybody returns for an appointment, but we have a very active secretary who attempts to contact those individuals who don't come back for their clinic appointments.

One point that I would like to add. We talked about HIV positivity as being important as information for the patient. In addition, I think it is important to stress that the immunological tests are very important as monitors of their status, and we attempt to repeat these at regular intervals as well, specifically doing T-4 counts, or CD-4 counts, to determine whether or not the immunological status is deteriorating, informing the patient that these may in some way be related to the risk of the occurrence of opportunistic infections. And also, we inform them that they may be eligible for participation in treatment trials, specifically the VA Cooperative Study and/or the open treatment with the AZT. So, patients have become aware of the importance of following these immunological parameters as well as having clinical followup; and this has encouraged them to return to our clinic.

Mr. **Steinberg**. Dr. Gronvall, let me just make a comment. I assume that the new task force that you describe, in terms of looking at the 1988 allocations, will obviously be focusing on the AZT costs, which could not have been fully considered in the 1987 allocations. Is that a fair assumption?

Dr. **Gronvall**. I don't know that it will focus on that, but that is part of the deliberation.

Mr. **Steinberg**. That will be part of it?

Dr. **Gronvall**. Yes.

Mr. **Steinberg**. That will be clearly part of it?

Dr. **Gronvall**. Yes, it will.

Mr. **Steinberg**. I might indicate to our three field witnesses that a concern about these reimbursements for 1987 and 1988 was strongly held by the committee, both the majority and the minority; and we were very pleased that the VA did make a commitment as to 1988 that the adjustments—to the extent that they could project them—would be made at the outset of the fiscal year rather than, as was the case this year, 9 months into the fiscal year.

Of course, we can't anticipate the future entirely, but we think that is real progress; and we appreciate Dr. Gronvall's cooperation in moving to that result.

Do each of you have drug treatment programs at your medical centers? I know that Manhattan does.

Dr. **SIMBERKOFF**. Yes.

Mr. **STEINBERG**. You do?

Dr. **GORDON**. And we do, too.

Mr. **STEINBERG**. I certainly knew that. What efforts do you make to encourage patients in the drug treatment programs to be voluntarily tested? I know that Dr. Crow, for example, indicated that the test was offered to them. I am asking about encouraging them to be tested because they are obviously potentially in a high-risk group.

Dr. **CROW**. Maybe I could respond to that, at least to begin. We have both an inpatient drug treatment program and an outpatient drug treatment program that is primarily methadone maintenance. In both centers, the involved physicians—the supervisory physicians—are very interested in this problem and have made a concentrated effort. I can't give you numbers, but I do know that the effort is certainly there. The effort has been intensified recently in our outpatient drug treatment center in that the involved staff have put together a research protocol in an effort to test not only the patients but also their steady sex partners or spouses along those lines. And I think that will give us a lot of information from that standpoint.

We do make an effort, but I can't give you numbers as to who gets it, how many get it, or how many refuse, et cetera.

Mr. **STEINBERG**. Dr. Gordon.

Dr. **GORDON**. I don't know how aggressive our staff has been in that area, but certainly I strongly feel—as I have indicated before—that this group should be offered and encouraged for voluntary testing.

Mr. **STEINBERG**. Would you try to determine how much encouragement they are giving; and if they are not giving enough, would you perhaps suggest that they give more? And would you advise us of the results of your looking at that, please?

Dr. **GORDON**. Yes, I will.

Mr. **STEINBERG**. Dr. Simberkoff.

Dr. **SIMBERKOFF**. I think that a program to strongly encourage the testing of all risk groups of individuals who are entering drug treatment programs or being seen in the emergency room or clinics of the hospital or admitted to the hospital is really just now beginning to be formulated in an effective fashion.

Mr. **STEINBERG**. Are you talking about at your facility?

Dr. **SIMBERKOFF**. At the facility. Up to now, the test has been offered really only on a sporadic basis for individuals, usually after the house staff or one of the attending physicians has recommended that a patient should be tested and approached that individual for the test.

But we are now beginning to emphasize an educational program and a testing program on a much more widespread basis; and we hope to see some fruits of that in the very near future. The facilities for this obviously need to be put in place.

Mr. **Steinberg**. But each of you agrees with the policy of encouraging voluntary testing for high-risk groups?

Dr. **Simberkoff**. Right.

Mr. **Steinberg**. Is that correct?

Dr. **Gordon**. Absolutely.

Dr. **Crow**. Yes.

Mr. **Steinberg**. And would you say that it is your opinion that that is Central Office DM&S policy at this point, as has been communicated to you?

Dr. **Simberkoff**. Yes.

Mr. **Steinberg**. That encouragement?

Dr. **Crow**. Yes.

Mr. **Steinberg**. But that, in essence, it is a program that is just getting started at this point?

Dr. **Simberkoff**. Yes.

Mr. **Steinberg**. Dr. Crow seems to perhaps be the furthest along in that regard.

Dr. **Crow**. I don't know whether that is a compliment or not; but at any rate, we have been actively trying to get these folks, those in recognized risk groups. As I said, it is actually a part of our hospital policy that was written 2 years ago, stating that these are the groups that should be tested, and they should be offered the test.

Mr. **Steinberg**. Dr. Gronvall, is it correct to say that that is Central Office policy that medical centers should encourage high-risk groups to be voluntarily tested?

Dr. **Gronvall**. I believe the answer to that is yes. I don't know of my own knowledge that we have issued a statement specifically in that regard. Earlier, there was discussion about the review that has been going on in the VA about the issue of testing and how it could be expanded. And there was discussion of a document that we had developed that describes a proposal for significant expansion of testing in the VA, and that issue is at the heart of it to identify those veterans who come to us for care who are in programs such as drug testing where they have a higher risk of being infected and to find ways on a system-wide basis to expand testing and the availability of testing for those veterans.

Mr. **Steinberg**. I think your answer was: I think that is the policy?

Dr. **Gronvall**. I am not aware of whether we have issued a formal directive or policy statement to say every medical center should begin taking steps to aggressively offer testing to all veterans who are in drug treatment programs.

Mr. **Steinberg**. Is that a good policy?

Dr. **Gronvall**. Dr. Cohn should really comment on that. It is certainly a good policy, and it is, as I say, under development to expand.

Dr. **Cohn**. As I said in the earlier testimony, when we first appeared, the two cardinal areas in which we have given guidance are the use of the test as an aid in the diagnosis of AIDS or ARC—so a clinical indication clearly—and a second indication, of course, is the use of the AIDS antibody test in Project Lookback, the transfusion-related AIDS. Those are the two areas where we have issued specific guidance. We have had discussions on individual bases with various chiefs of staff, but there is no specific language addressing that.

Mr. STEINBERG. And I think I understood the Chief Medical Director to say that he believes that would be a good policy?

Dr. COHN. That is what we are in the process of developing. That is the position paper that was alluded to considerably earlier this morning.

Mr. STEINBERG. And that would apply not only to drug patients, but there are certain other connected conditions and certain other indications that individuals may be in high-risk categories. Is that correct?

Dr. COHN. Yes.

Mr. STEINBERG. And how long will it take, would you think, to get specific guidance to your medical centers, encouraging them to aggressively offer the test to persons in those categories?

Dr. GRONVALL. It is a little hard for me to put a specific date on it because the recommendations we have been developing are planned for deliberation at the Domestic Policy Council and I believe a presidential decision or an Administration decision about what the character of the expanded testing will be in the Veterans' Administration. I think that will require that that kind of decision be made. We are working on the details, of course, of such an expanded program, what the costs and other implications would be, the need for counseling, and all of the other attendant things that would have to be done to make a major expansion of testing of the sort we are describing.

Mr. STEINBERG. You think what we are talking about here is a major expansion? I am sorry. When I say here, I mean in the last 5 minutes.

Dr. GRONVALL. I don't know about the definition of the word "major," but for us to adopt as a VA system a system-wide set of programmatic requirements that, through all of our drug abuse programs or substance abuse programs, we explicitly expand the counseling of every veteran, to encourage every veteran in those programs to be tested and to followup with counseling on the results of the tests would be a significant expansion of testing in that aspect of a VA program.

Mr. STEINBERG. Testing and counseling?

Dr. GRONVALL. Yes; testing and counseling. When I say "testing," counseling is presumed to be a part of that. And like any other program that we want to adopt system-wide, it requires some thought to ensure that we have a realistic timetable for doing it, that we make the resources available, the guidance available, that we have the staff who can do it, et cetera, et cetera.

Dr. SIMBERKOFF. I would just like to make one additional comment. That is that we have had an ongoing study in our drug abuse program—our Methadone Maintenance Program—which actually began almost 4 years ago, a progression study of the patients for immunological dysfunction, which actually began before HIV was recognized. Retrospectively, it was shown that HIV was the cause of the immunological dysfunction that was being observed and followed in these patients.

It now includes most of the patients that are being followed in the Drug Detoxification and Methadone Maintenance Program. One of the biggest problems that we have in our facility, as well as one of the biggest problems that is present in all of New York City, is the fact that our programs are filled. There is no room for additional individuals to be included in the Methadone Maintenance Program. We have difficulty, when new patients come into the hospital and wish to be entered into drug detox or Methadone Maintenance Program, of finding an available place for them.

So, it is more than simply expansion of the availability of testing programs and counseling programs. One has to also have available for patients places where they can be given the type of treatment that is necessary to allow them to stop the high-risk activity which leads them to the infection in the first place and may result in further spread of the infection, even after it is known that it is present.

Mr. STEINBERG. I think we understand the problems of resources and, indeed, Senator Cranston had a number of comments about what demand on resources might be made by a substantial expansion of testing. I must say I find it strange, I suppose, that we would be talking about what I think nobody as a matter of policy would quarrel with, that is, that we ought to be trying to get more people who are at high risk for having the virus tested. I mean, certainly all the testimony this morning was to that effect from the Administration and from all our witnesses and from the three of you. And Dr. Gronvall has very carefully indicated—and I am sure very properly—serious reservations about moving ahead too quickly with any such policy until we know the implications, until we are sure that it would be done right, until we are sure we would have the resources in place to do it.

And yet, there are apparently some people in the Administration somewhere—if one believes the New York Times—who believe that we can put in place in our lifetime a program of testing all 1.4 million VA hospital admissions a year. And I find your testimony very careful and appropriately cautious about doing this in a clear high-risk category where everybody agrees that it is good public policy. Whereas in the area of 1.4 million, I think it is fair to say not everyone would agree that it is good public policy. Indeed, the burden of our testimony this morning is that it is not; and yet, that is being seriously looked at, even though the implications for resources and doing it properly, are so substantial for what appeared to me to be a very modest expansion of what is going on.

Now, I just have to surmise from that, regardless of what policy dictates may be considered or may be made actually, it is going to be a long time before the VA would ever have in place a program where it could test all 1.4 million hospital admissions. Tony, I don't know if you have any thoughts to share on that. It just struck me as interesting, particularly in light of Senator Murkowski's concerns, which Senator Cranston shared, about trying to get certainly high-risk people tested. How would we go about doing that? It is obviously not as easy as talking about it.

Let me ask a couple of questions about the ELISA test and your costs, if I may, for that test and for the Western blot confirmatory test. How much contracting are each of you doing? How much of it is being done by sending the samples to Lexington? Do you want to start, Dr. Crow?

Dr. CROW. Sure. We are doing all of our ELISA testing in our facility—all of it.

Mr. STEINBERG. You are doing it yourself?

Dr. CROW. Yes, we are; that cost is running us, I think, about $5.50 per test—per patient if you will. At the present time, Mr. Steinberg, we are not sending out routinely confirmatory tests because right now we are in the process of primarily testing patients who are at high risk and therefore have a very high prevalence of disease. The use of the confirmatory tests, such as the Western blot or some of the others, we think has very little value.

We have sent the confirmatory tests——

Mr. STEINBERG. Is that because these people are symptomatic? Is that what you are saying?

Dr. CROW. That is because these people are symptomatic and/or in a high-risk group, where the prevalence is high and therefore the incidence of false positives is very, very low, as was made reference to earlier.

The confirmatory test, that is, the Western blot, we have used in areas where a patient may have a symptom complex that is consistent with HIV infection but not be in an identified risk group; in that setting we will routinely send out the confirmatory test. I am sorry that I don't know the cost of that particular assay. We do send it out. I don't know whether it goes to Lexington or some local contractor. I don't know.

Mr. STEINBERG. Dr. Gordon, I will get to you in just a moment. Mr. Crow, you are saying that you would make a finding or diagnosis that an individual does have the HIV virus and enter it into the medical record without a confirmatory test, as long as there is a positive test result the first time on an ELISA test for a high-risk person. Is that correct?

Dr. CROW. We do two ELISA, if you will. The test is done twice before it is called positive; if it is positive on both determinations, then we call that a positive test. Given the patient's situation, if that is a likely diagnosis, then, yes, we will enter that into the medical record.

Mr. STEINBERG. Would each of you comment on that issue specifically and answer the question generally about your experiences with the ELISA test and the Western blot in terms of cost and contracting? Dr. Gordon?

Dr. GRODON. Up until this point in time, we have sent all of our tests—the ELISA as well as the Western blot—to be done at Lexington. I have the impression that they are to their full capacity; and if we are to expand voluntary testing, we would have to go to the open market. For the ELISA, this would be $30 that we could get it for with the UCLA Medical Center through our sharing agreement. The Western blot would cost us $104 at Smith-Klein.

But I think for a limited number, we could handle this within the funding that we have recently been provided. In addition, we do spend a fair amount on T-4 cell tests, which we get in the local community for $45 a test.

Mr. **Steinberg**. This is to determine the extent to which the immune system is impaired?

Dr. **Gordon**. That the immune system is impaired.

Mr. **Steinberg**. Do you want to comment on the point that Dr. Crow made about when an individual in a high-risk category is diagnosed as having the virus? I was surprised to hear that. I had thought that the Western blot test was routinely done. So, that is why I am asking you each if you would comment on it?

Dr. **Gordon**. As far as I know, the Western blot is only done on those that have a positive result.

Mr. **Steinberg**. That is what I am saying. Dr. Crow's testimony was that, in the high-risk individuals and in individuals who are symptomatic, if they have two positive ELISA results, they do not test further.

Dr. **Gordon**. Oh, I see. I can't answer that.

Dr. **Simberkoff**. Our practice is actually to do ELISA's, Western blots, and T-4 lymphocytes, all in the house. It has been done in Dr. Susan Zolla-Pazner's laboratory. She actually was one of the pioneers in describing the immunological abnormalities of AIDS. She has been following the immunological abnormalities as well as determining the prevalence of AIDS antibodies in the population.

The costs of the tests, I think, are comparable to those that have been quoted. I understand that the ELISA costs around $5, the Western blot somewhere around $20. The costs of all of these tests are sort of artificial in the sense that a group of technicians that does all of them, their salaries are not included.

Mr. **Steinberg**. Right.

Dr. **Simberkoff**. It is mainly for reagents. It is actually our practice to do all tests in anybody who is positive, in other words, if an ELISA is confirmed by a Western blot. We would have great reservations about not confirming a test or reporting a test as positive if it were not confirmed and certainly also not determining the patient's immunological status prior to talking to them. We think it is very important to give both him (the patient) as well as ourselves an idea about the extent of immunological dysfunction that is present so that we can more intelligently discuss with him what he might expect.

Mr. **Steinberg**. So, that is why you do the third test in all cases?

Dr. **Simberkoff**. Right.

Mr. **Steinberg**. Does your laboratory also do testing for the other New York facilities—the VA New York facilities?

Dr. **Simberkoff**. They have on occasion sent serum to us.

Mr. **Steinberg**. But it is not routine?

Dr. **Simberkoff**. It is not on a routine basis. I think that we have encouraged them to do so, but for whatever reasons they have chosen in most cases to send them to other laboratories.

Mr. **Steinberg**. It sounds like—Dr. Gronvall, if I might interject—that if we move into larger testing programs, which it seems to me you are going to inevitably do, certainly for high-risk individuals, that perhaps the Manhattan, if appropriately augmented, might be able to serve as a resource for the east coast at least, rather than our having to go out into the marketplace and pay four, five, or six times the cost of an in-house test. I am sure you will look at that.

Dr. **Gronvall**. Oh, absolutely. And you made the comment earlier that, even when we were talking about the perhaps modest expansion of testing that would be carried out through veterans in our drug abuse program, as we look ahead I think it is quite clear that we are going to be significantly expanding testing, under whatever banner that program is developed. And one of the reasons why I earlier was exercising restraint in talking about how soon we could do that and to what extent is that we are looking at all those options.

We do have half a dozen of our medical centers now able to do the full array of sophisticated testing; but we want to be sure that, before we make any specific projection of a major expansion of testing, we have the capability, have the plans in place, know which laboratories will be expanded, what the costs and other implications of that are, and so on.

Mr. **Steinberg**. As I said, I thought that was most prudent and appropriately cautious.

Dr. **Gronvall**. I appreciate it.

Mr. **Steinberg**. Do you have any comment, Dr. Gronvall, on the issue of confirmatory tests? Does the department have a policy? My concern is that, once it is entered into the medical file—as it would be for example in Houston—that the individual has been confirmed as having the antibody and presumably having the virus, that is a pretty serious matter for that individual medically, socially, and in every way.

We have received considerable testimony that certainly the VA can't guarantee the confidentiality of the medical record and that that information might become available to an insurance company or who knows whom else. I am just wondering if you were surprised to hear that as well?

Dr. **Gronvall**. Let me ask Dr. Cohn to comment and to speak to the departmental policy because we have addressed that issue.

Dr. **Cohn**. Every consideration, every discussion, every policy pronouncement, every meeting I have ever been to, I have always heard that one must perform the Western blot as a confirmatory if either of the first two ELISA's are positive.

Mr. **Steinberg**. Is that departmental policy?

Dr. **Cohn**. Yes, sir, in the areas which I addressed in my earlier response to you.

Mr. **Steinberg**. If someone is tested, and the test is positive——

Dr. **Cohn**. This is the ELISA you are talking about?

Mr. **Steinberg**. Yes. Is it Department policy that there shall be at a minimum a confirmatory Western blot test, perhaps a second ELISA test? But at a minimum, there should be a confirmatory Western blot?

Dr. **Cohn**. Yes, sir.

Mr. **Steinberg**. And is that written policy?

Dr. **Cohn**. As it relates to the two programs I have mentioned. Yes, that is the policy.

Mr. **Steinberg**. We are saying that the test has been performed in a VA facility?

Dr. **Cohn**. Yes, but your line of questioning has moved over into another, broader area. I can only address the policy issue related to the testing that we have spoken about in policy.

Mr. **Steinberg**. No, I am only talking about the actual testing that is going on at the moment. As to testing that is going on at the moment, which could be pursuant to either of the programs that you indicate, or because somebody voluntarily requests to have a test made——

Dr. **Cohn**. The Western blot should be done as a confirmatory.

Mr. **Steinberg**. And since that apparently is not being followed throughout the system, I would suggest that perhaps there is a need to reinforce that policy through a written issuance, but perhaps as well through one of your phone conferences.

Dr. **Gronvall**. You yourself made the comment earlier that one of the ways that information surfaces and circulates is through congressional hearings. We appreciate the surfacing of this question today, and we will certainly followup on it.

Mr. **Principi**. I would like to ask a question. I sense that it sometimes becomes a blurring of civil rights and medical issues. Certainly, first and foremost in my mind, is the fact that AIDS is a medical issue and not a civil rights issue, notwithstanding the fact of the need for privacy and confidentiality. The lack of any absolute certainty with respect to confidentiality and assuming that you do the requisite ELISA test and Western blot, is there medical justification for placing the findings in the medical records? Is that most important from a medical-clinical perspective?

Dr. **Simberkoff**. In my opinion, it is because it alters the differential diagnosis, that any physician seeing this patient might wish to entertain for any set of symptoms or signs that that patient exhibited. Knowing that this individual has been infected by HIV will certainly alter his susceptibility to a variety of infectious agents and make him a more likely candidate for a number of malignant diseases.

We have already said that sometimes these patients go to different clinics and are seen by different physicians on different occasions. These physicians—whether it be an oncologist or an infectious disease specialist, a gastroenterologist or a pulmonologist—will be thinking about different diagnoses if they know that that individual has HIV infection and a set of symptoms than if that individual is not known to have HIV or just a person appearing off the street with that same set of symptoms.

Mr. **Steinberg**. Dr. Gordon.

Dr. **Gordon**. From my early comments, I have great concerns about confidentiality. This can mean loss of life insurance, health insurance and, goodness knows, what else. This is why I have taken a more strict approach, but we do make certain that the primary physician gets the report verbally so that those who are caring for the patient who have a need to know, do get the report verbally. Now, this does have drawbacks to it, and it is going to be an increasing problem if we expand our testing voluntarily to other groups.

It is a real concern to us, and perhaps you can help in the legislative field.

Mr. **Steinberg**. It is pretty clearly a no-win situation.

Mr. **Principi**. It sounds like it.

Dr. **Crow**. I think that result does have to be in the medical record. From a medical care standpoint, I believe the access has to be there. I do think the possibility of discrimination in the social sphere is a real one, though I will also admit it hasn't developed to the extent that I was afraid it might, at this time 2 years ago.

But I do think that the availability of the result in the medical record is important. As Dr. Gordon described, in Houston we have taken efforts not to put that result in the computerized laboratory profile of these patients, but instead, by hospital policy, ask that it be included in a progress note.

Mr. **Steinberg**. Dr. Cohn?

Dr. **Cohn**. May I say something.

Mr. **Steinberg**. Please.

Dr. **Cohn**. I would like to borrow on the words of Jim Curran. He didn't say it today, but I have heard him speak a number of times; and I have a lot of respect for him.

The reason why it would appear that perhaps we are struggling and we have some differences of viewpoint is that we are living—literally living—through this epidemic, and it is obviously very complex. Every issue we discuss within it—whether it is confidentiality, drug treatment, vaccine development, or what have you—is an extremely complex issue.

So, it is little wonder that we do have some differences of view and differences in terms of where records are kept or where they aren't. I think we clearly need stronger confidentiality laws, and I have expressed that in House hearings; and I think the Congress can help us there. So, I don't find it at all surprising, indeed, that we are having some trouble coping because we are living through a very serious epidemic.

Mr. **Principi**. Thank you, Jonathan.

Mr. **Steinberg**. As I said, this is pretty much a no-win situation. I would have to comment to Dr. Gordon that we don't have complete continuity of care in the VA, and, obviously, the fact that a physician has been advised of the result of the test—and we are talking about a positive result in terms of the points that Dr. Simberkoff and Dr. Crow have made—does not mean that a subsequent physician treating that patient will ever know it. It grieves me to make that comment because I admire your tremendous sensitivity to the confidentiality neads of your patients in this regard.

And I share completely your view that, once it is in the medical record, it is very difficult to protect that information. I think it is impossible to protect it, and I don't know where this can lead, but it is very troublesome to me.

Dr. **Gordon**. As I indicated, this does have some drawbacks and this has been of concern to me and particularly as we get higher numbers of patients. This is another reason why I have appointed an AIDS coordinator, so that at least we can have continuity.

Mr. **Steinberg**. But that is not going to deal with this particular issue because these people are asymptomatic by definition.

Dr. **Gordon**. Oh, yes.

Mr. **Steinberg**. Dr. Cohn mentioned the confidentiality concerns and the need for stronger laws, and we have submitted a written question to you on that; but I am somewhat puzzled as to what the law can do in this situation that can really control human nature and human behavior in a hospital setting.

When it becomes known, and it is there in the medical record, that this individual is antibody positive, virtually everybody on that ward, if not on that floor, involved with patient care is going to know that. I think that is going to follow, and I presume some would say they should know that. Dr. Simberkoff, you are shaking your head.

Dr. SIMBERKOFF. In the first place, I think when you reach a situation where a substantial number of patients are known to be either HIV positive or to have AIDS, the significance of any one individual having that diagnosis tends to diminish.

Mr. STEINBERG. Meaning it is not necessary to be known for purposes of protecting hospital workers?

Dr. SIMBERKOFF. Exactly. One of the other hats that I wear in the hospital is Chairman of the Infection Control Committee. The AIDS problem has taught us the importance of stressing appropriate infection control practices on all individuals at all times.

Mr. STEINBERG. Right.

Dr. SIMBERKOFF. In a hospital in which the prevalence of HIV may be very high, and certainly that is true of all three of our institutions, we have to assume that every patient that we see at almost every encounter might be infected. So, the appropriate practices are necessary, as was stressed by one of your previous witnesses from the American Nurses' Association.

Mr. STEINBERG. Right.

Dr. SIMBERKOFF. And I think this has certainly become the case in our hospital where we are now stressing mandatory wearing of gloves for all blood drawings, transportation of blood specimens in an appropriate fashion to the laboratory and the handling of all bloods in the laboratory with gloves and appropriate precautions. This is done so that the accident which may occur with the blood tube which has not been labeled will be avoided and so that we don't have to worry about labeling only those individuals that we recognize.

I think that the experience that Dr. Curran referred to with the three health-care workers where AIDS was not even suspected, needs to be a lesson to us. Even after the problem of HIV has been solved, there will be other viruses. We currently can think of non-A, non-B, as being a potential infectious agent transmitted by blood; and there certainly are other retroviruses, perhaps HIV-2 or other viruses, which will be coming along in the future.

We have to stress for the future infection control in handling all blood specimens and alter our practices now using AIDS as the example.

Mr. STEINBERG. That is certainly excellent advice. Dr. Gronvall.

Dr. GRONVALL. I would like to make a comment on this issue of the medical record. I believe that, whatever else AIDS is, it is at heart of course an infection with a virus that leads to a tragic disease; and it is at heart a medical issue. For the long pull then, I at least always want to come down on the side of creating a record for each individual veteran patient who comes to us that is full, accurate, and contains the best possible information that is relevant to the medical status of that veteran.

I am extraordinarily concerned about the confidentiality aspect, but I believe we have ways of working on that. I would never guarantee the confidentiality of a medical record because I think that is not humanly possible; but I believe we can work on that. There have been many references to the fact that we are at the early stage of this pandemic, and most of the questions cannot be answered with clarity. That surely is true, but it is to me absolutely predictable that at some time in the future—hopefully it will be in the near future—there are going to be new advances.

There will be either drugs that can arrest the progression of the disease, hopefully even drugs that could eradicate the virus, and then ultimately a vaccine that could prevent it.

At the point, let us say, where a drug is developed that can eradicate the virus, I want us in the VA to be in the position of having the medical information available as to veterans that have been infected but are, at that time, not yet symptomatic so that they can be contacted, and we can make available that treatment. So, as I look down the road, that and a lot of other speculative questions that you could pose, it seems to me, all will be benefitted by having accurate, comprehensive, and clear medical information that is available about each veteran patient that we are caring for.

So, I come down, as I said earlier, on the side of treating this as a part of the medical record.

One other comment. I guess I don't like to think of myself as a senior physician in terms of age, but I am old enough to remember that, when I first was in medical school, at that point I even heard the remnants of somewhat similar discussions about cancer—not entirely a comparable situation. But there were people that I remember having heard say that the information about a patient's cancer should not be specifically documented and that the individual and the family should never know about this because no one could live with that terrible knowledge, and it would destroy the individual. Well, over time, I always want to come down on the side of the information and the informed and explicit honesty in dealing with our patients, always working on their well-being and the well-being of the people around them.

And I think again, in the long pull, that can only be done when we have honest, accurate, full, and concrete information that puts our health-care delivery team in the best possible position of having the tools to deal with each individual veteran in a compassionate and humane way, bringing to bear the best that modern medical science has to offer.

And surely, the position that we are in right now is not where we are going to be even 6 months from now or a year or 2 years or 5 years from now. So, I am willing to build the record on that basis.

Mr. **Steinberg**. Let me note that we are very anxious to know whatever specifically you believe needs to be done to improve the confidentiality laws. We will be sending this afternoon a question with respect to that. We would appreciate a rapid response.

My comment was only that laws, Dr. Gronvall, can only do so much. And as you said, you cannot guarantee the confidentiality of the record. I feel very badly that we have brought our constituent all the way back here from Los Angeles and here he has found that he is in a sort of minority position on this. And the same thing has happened in one respect with respect to Dr. Crow. I am sure if we go on long enough, we will find one for Dr. Simberkoff also. [Laughter.]

And I trust that it need not be said—but rather is understood—that everyone here is obviously doing what they think is in the best interest of their patients—in the total interest of their patients—and if those things are not 100 percent in accordance with policy, then compliance can be brought about in appropriate ways, but that everybody has been proceeding in what they think is in the best interests of good health care. I am sure that that is understood, and that is a part of the context in which we are operating, although this is on the public record and this isn't a confidential or private forum. I sort of feel as though an apology is in order to each of you. We don't do the kind of extensive pre-hearing preparation that is done for the Iran Committee—I guess except in the case of Colonel North—and so, we don't know what answers we are going to get to all the questions.

If we get anybody in trouble, we apologize; and I am sure there won't be any trouble. Is that fair to say?

Dr. **Gronvall.** Oh, Mr. Steinberg, let me comment on that; I think quite to the contrary. We are living through an evolving pandemic, as we have all described. I have no belief that a major contribution to our ability to deal with this would be brought about by my issuing every day, or every other day, a uniform set of rigid rules and ensuring that everyone complied with them.

Mr. **Steinberg.** You will leave that to the Congress, is that right? [Laughter.]

Dr. **Gronvall.** I have a great deal of help on that issue from a lot of people here in Washington. In fact, I referred earlier to the genius of America, being that I think if we in the Central Office can help focus what the problem is, what the tools are that can be made available, it is in fact to our benefit to encourage and watch the creativity and innovative approaches in our individual medical centers; and in a collective way, we learn from that experience, and we have medical centers that are handling this issue in very different ways. In each case, there is a responsible physician and medical staff responsible; and differences in approach, I think, are not only acceptable but are in fact desirable as this disease unfolds before our very eyes.

So, I am not at all concerned to hear differences of approach being described.

Mr. **Steinberg.** Good. Tony, go ahead. I have only one last piece of information I want to address.

Mr. **Principi.** I have to depart, but I just wanted to say that this is probably the most informative hearing that I have had the privilege of participating—probably the longest in recent memory. [Laughter.]

I just want to thank the witnesses for their insightful comments and their contribution to this issue. Speaking on behalf of Senator Murkowski and other members on this side of the aisle, thank you very, very much.

Mr. **Steinberg.** Thank you. We certainly share in that view and thanks. I should close this hearing, but there is one other piece of information I would like to get, and then I will certainly echo Tony's sentiments.

If an individual tests positive on the first test, and then a followup test is done—either another ELISA or the Western blot—and it is determined that that was a false positive, is there any notation in the medical record of there having been a false positive? Or is there just a final notation that it was negative?

Dr. **Simberkoff**. That would be recorded as a negative, if it was truly a negative. Now, there are circumstances that I think you have to be aware of where one can get an equivocal Western blot, which would require——

Mr. **Steinberg**. Now, I am just saying that where it was determined that it was a false positive, it would never be shown as a positive of any sort?

Dr. **Simberkoff**. Right.

Mr. **Steinberg**. Dr. Gordon, in your system, would that be the case as well?

Dr. **Gordon**. If we got a false positive back, you know it would take time for us to become aware of this. Right?

Mr. **Steinberg**. It would depend on the circumstances.

Dr. **Gordon**. But certainly, this should be corrected, and the patient has to be called in and this explained, and the record changed accordingly.

Dr. **Simberkoff**. In our case, the patient wouldn't be informed until the confirmatory test was done; and no information would then be put on the chart concerning the initial false positive finding.

Mr. **Steinberg**. Dr. Crow, do you have any comment?

Dr. **Crow**. Sure. The way we are going to handle that is to note it in the medical record. Now, the issue of going back and changing the prior medical record—since we report our results in a progress note—would certainly be a problem. I don't think I have a response for that, Mr. Steinberg.

Mr. **Steinberg**. So, we do have, in essence, two or three different policies And I won't pursure this further because I don't know what the answer is. But it is an interesting issue, and perhaps it ought to be looked at as to what ought to be done, whether or not there should be a progress file type of note or whether or not the file should——

Dr. **Simberkoff**. We could go on forever, but I think it has to be pointed out that there are many reasons for false positives, including the fact that there may be other retroviruses present, which can give false positive reactions, and which become very significant in terms of followup of patients.

Mr. **Steinberg**. Right.

Dr. **Simberkoff**. So, this is one of the other things that has to be looked for.

Mr. **Steinberg**. I am far in over my head.

Let me conclude by echoing what Tony said, and again regretting that Senator Cranston could not remain here. As you know, he was here in excess of 3 hours. We thought it was very important to cover as many topics as we could with the Administration witnesses and the other witnesses.

Your contributions have been of enormous assistance to all of us. We thank you for your time and for traveling here. Let me note in closing how much the committee appreciates the policy of Dr. Gronvall and his staff. All of the witnesses, I should note for the record—not just Dr. Gronvall and Dr. Cohn, but Dr. Mather, Mr. Lindsey, Dr. Greene, and Mr. Ibson—have remained here through this entire hearing. We greatly appreciate that degree of attention and the obvious concern that it manifests.

We think that is an excellent policy. And I know the committee would want me to thank you very much for your courtesy to the witnesses and to the committee and for your show of commitment. We stand adjourned.

[Whereupon, at 2:10 p.m., the hearing was concluded.]

APPENDIX

STATEMENT OF
JOHN A. GRONVALL, M.D.
CHIEF MEDICAL DIRECTOR
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 24, 1987

Mr. Chairman and Members of the Committee:

I am pleased to be here today to provide the Committee with an update regarding the impact of AIDS (Acquired Immune Deficiency Syndrome) on the Veterans Administration.

The Epidemic in the U.S. and VA Experience

AIDS is a devastating disease. It is but one manifestation of HIV (Human immunodeficiency virus) infection. In the United States over 36,000 cases of AIDS have been reported to the Centers for Disease Control (CDC). Over 1.5 million people in the U. S. are thought to be infected and many feel this is a conservative figure with estimates ranging as high as 4 million but no one knows for sure. HHS will conduct an epidemiological study to determine the incidence of AIDS in America. In terms of those who will go on to develop symptomatic disease, the estimates range from 25-70%. The cumulative death rate is over 55%; the case fatality rate is approximately 85% for those who have the disease for three or more years. No cures have been reported.

The VA's case load has ranged from 5.3 - 5.8% of the total number of cases reported to CDC. From September 1983 to May 1987, 2,014 cases of "full-blown" or CDC-defined AIDS have been reported to VACO. Ten (10) VAMCs have reported 1,194 of these cases or approximately 60% of the VA total. The Centers with the highest number of cases reported during this period are:

New York (Manhattan)	324
West Los Angeles	131
San Francisco	118
Bronx	118
Miami	102
Brooklyn	99
East Orange	95
Houston	75
San Juan	73
San Diego	59

One hundred eleven (111) VAMCs have reported at least one case. The impact on the VA is therefore differential in character: moderately-heavy on several of our Centers, minimal on the majority. The VA Medical Centers in New York State have treated nearly 30% of the total, those in California 21% of the total. Based on the data presented at a conference sponsored by the Department of Health and Human Services in June, 1986, in Berkeley Springs, West Virginia, the situation is predicted to worsen dramatically by the end of 1991: 270,000 total cases cumulatively with nearly 180,000 deaths, again cumulatively, since the beginning of the epidemic in 1981. These figures are now being revised upward due to a modification of case definition by CDC. The VA's cumulative caseload could equal 14,000 cases by 1991 based on these data. However, it is anticipated that the Department of Defense policy on screening all active duty personnel and recruits could modify the VA's future case load. Because the veteran population is composed of relatively few females, increasing numbers of women and children expected to be affected in the future will have less impact on the VA than society at large.

The treatment of AIDS patients is both labor-intensive and cost-intensive. A host of medical specialties and subspecialties are involved, as well as a significant number of staff members from a variety of allied health arenas, including Social Work Service, Pharmacy, Chaplaincy, etc.

Laboratory Support

Laboratory Testing for the antibody to the AIDS virus serves a variety of clinical purposes including: (1) part of the diagnostic work-up of a patient, (2) part of the "look-back" program to determine if patients transfused with blood or blood products prior to the availability of the ELISA test (3/85) are antibody positive, (3) voluntary screening of individuals or groups at high risk, (4) corroborative or confirmatory testing (the use of the Western Blot to confirm a positive ELISA), (5) "tertiary" testing - the performance of sophisticated studies to determine the status of a given patient's immune system (e.g., T4/T8 ratios).

The VA has provided guidance to its field facilities that testing for the antibody to the AIDS virus should be performed when clinically indicated, i.e., in aiding in the establishment of a diagnosis, and in collaboration with the various blood banking associations in the U.S. (project "look-back").

In response to the challenge of AIDS, the VA has expanded the Reference Center for Serology at VAMC Lexington to serve the agency as a laboratory to test for HIV antibody. This facility provides both screening and corroborative testing. Growth of this service has been exponential as AIDS cases have increased, resulting in maximum productivity by the laboratory.

The increased pressure for AIDS testing at VAMC Lexington with its rapidly mounting costs has resulted in the development of a new and innovative method for financing this program, referred to as the "charge back system." This will allow VAMC Lexington to charge other VA medical centers for AIDS testing services. The cost to the VA for screening tests is approximately $5.00 per test and the cost of the corroborative test is $17.00 per test. The cost for this testing service on a fee basis arrangement in the private sector would range from $12.00 to $30.00 and from $25.00 to $45.00 respectively for screening and corroborative procedures.

In 1985 the VA anticipated the approaching demand for tertiary testing for AIDS which requires a flow cytometer and monoclonal antibodies. To meet this need, the VAMCs in New York, Albuquerque, San Francisco, Denver and New Orleans were provided with this technical capability.

The cost to the VA to perform tertiary testing by flow cytometry will vary from $90.00 to $120.00 per specimen depending on the number of monoclonal antibodies used. This same service on a fee basis arrangement ranges from $400.00 to $600.00 per specimen in the New York area.

Costs of Caring for AIDS Patients

There have been numerous attempts both in the VA and out to arrive at cost projections per case. In order to be responsive to facility needs, we have attempted to find a more rational way of funding facilities for AIDS cases. As you know, a facility's resources are based on workload performed two fiscal years prior. Because AIDS is a relatively new disease that is increasing at a rapid rate and is unevenly distributed around the country, it is a special challenge for the few hospitals that care for the majority of the Agency's AIDS workload.

Several months ago a questionnaire was devised that was sent to 11 facilities that had a high number of reported AIDS cases. The questionnaire asked them for certain information concerning their last 10 AIDS patients in FY 1986. Using this data, we estimate that our Resource Allocation Methodology has provided funding of approximately $6,000 per AIDS case to VA Medical Centers.

In FY 1985, we estimated that it cost $38,000 per year to treat an AIDS patient. A more recent study determined that $24,000 a year would be more appropriate.

Based on reduced lengths of stay, less use of intensive care unit days and better facilities to manage these patients, it is believed that the cost of an AIDS patient has decreased about 20% since FY 85. As a result, we are using $20,000 as an estimate of cost per patient per year for FY 1987. Based on this, supplemental funding has been provided for those facilities that have seen more than 15 cases in FY 1987.

Although costs do appear to be coming down, the treatment outlook is unchanged (except for the emergence of zidovudine, formerly called AZT - for selected cases). Increased use of this drug will offset reduced costs. The drug itself costs from $7-10,000 per year per patient. Also, since the drug is toxic and requires close monitoring, including various laboratory studies, additional costs are incurred.

Intergovernmental Coordination

We are working closely with other Federal agencies to coordinate activities related to this epidemic. An example of one such partnership is the DoD/VA Working Group co-chaired by Dr. H. D. Cohn of the VA's Department of Medicine and Surgery and Captain V. Schinski from the Assistant Secretary of Health's Office in DoD.

The purpose of the DoD/VA Working Group is twofold:

(1) to exchange recent and evolving research and clinical developments

(2) to work toward effecting the smooth transfer of patients with AIDS or the lesser syndromes (e.g., ARC) from the military to the VA health care system. (It is projected by DoD officials that approximately 550 persons will be medically discharged from the three services over the next two years, potentially seeking continuation of their care in the VA).

The VA has also been an active participant in other groups, including the White House Working Group (WHWG) on AIDS, a group now chaired by Mr. Gary Bauer, Policy Advisor to the President. Discussion continues in response to a decision by the President to review all Federal programs where expanded testing would be appropriate. Dr. H. D. Cohn also serves on the Federal Coordinating Committee on AIDS Information Education and Risk Reduction and represents the VA on the Intragovernmental Task Force on AIDS Health Care Delivery.

Education Activities

In addition to the provision of high quality clinical care for patients with AIDS or ARC, the VA, of course, has a heavy commitment in terms of educating its health care workers. In this regard a variety of educational programs have been conducted throughout the system:

- 30,500 VA staff trained in FY 1985 at 129 VAMCs involving individuals from all Services.
- 13 RMEC (Regional Medical Education Center) sponsored AIDS programs in FY 1986 - 1,530 VA participants
- 12 CE activities sponsored by CHEPS (Cooperative Health Manpower education Programs) in FY 1986 - 545 VA participants
- 3 RMEC sponsored AIDS programs in 1987 - 440 VA participants - others in planning stages (Birmingham - Cleveland - Seattle*).

  * held May 14-15, 1987
- 15 Dental Education Center sponsored programs - 980 VA participants

The VA is participating in the Red Cross "Look-Back" program which is designed to offer the AIDS antibody test and appropriate counseling to patients who received blood transfusions between the years 1978 and 1985. Also, the VA has participated in the distribution of the U.S. Surgeon General's Report on AIDS.

Mr. Chairman, as you suggested during your May 21, 1987, hearing, we intend to expand patient health education efforts targeted specifically to groups at higher risk of developing AIDS.

Research

The VA is engaged in the entire spectrum of research on AIDS from basic science studies of the mechanism of AIDS virus infection, through clinical trials of drugs in the treatment of veteran patients with AIDS.

In the area of basic research, a number of VA laboratories are studying the mechanism by which AIDS virus infects cells. Dr. John Ziegler of the San Francisco VAMC is studying the molecular events, triggered by AIDS virus infection, that result in the death of essential cells of the immune system.

Dr. Paul Hoffman of the Baltimore VAMC is using a mouse model of AIDS infection to understand how the virus attacks and kills nerve cells.
Dr. Bernard Poiesz of the Syracuse VAMC has been investigating the mechanism by which viruses, similar to AIDS virus, cause certain cancers of the lymphatic system in animals. This area of research is important to our understanding of why some AIDS patients develop these kinds of cancers. In other animal studies, Dr. Stephen Wright of the Salt Lake City VAMC is working on a vaccine for an AIDS related animal virus.

In the three years since it became established, the Virology Reference Center at VAMC West Haven has gained a nationwide reputation for service and excellence. While the Center has elected to continue offering standard viral serology services as its major mission, it has also established a laboratory for the culture of the AIDS virus. An anticipated benefit of this service will be to enable the center to test the effect of new drugs on the AIDS virus. West Haven is the only VAMC with the capability to grow this virus.

In the area of clinical research, Dr. Susan Zolla-Pazner of the Manhattan VAMC is investigating the impact of AIDS virus infection on the functioning of the immune system, and Dr. Michael Simberkoff, also of Manhattan, is attempting to improve therapy for the serious infections that attack AIDS victims because their immune systems malfunction. Dr. Wallace Tourtellotte of the West Los Angeles VAMC and Dr. Peter Dowling of the East Orange VAMC are studying infection of the nervous system in patients with AIDS. A number of other VA investigators (Drs. Dobbins, Ann Arbor, and Klotman, Durham) are studying "opportunistic infections" in AIDS patients.

Several VA investigators are actively engaged in the development and testing of new drugs for the treatment of AIDS infection. Dr. Raymond Schinazzi of the Atlanta VAMC is designing new drugs targeted against the unique biochemical pathways of the AIDS virus. Drs. John Bilello and Paul Hoffman of the Baltimore VAMC are supported by the NIH to test new, potentially useful drugs against AIDS. And the VA is carrying out a large scale, controlled clinical trial of the efficacy of zidovudine, formerly called (AZT) treatment in patients with AIDS-related complex (ARC). This trial is supported by special AIDS research funds from the Department of Defense.

Concluding Remarks

Dr. Jonathan Mann, AIDS Program official with WHO (World Health Organization), has described three phases that nations undergo in coping with the AIDS "issue" or the first AIDS case they encounter:

Phase 1 - minimization
Phase 2 - reluctant acknowledgement
Phase 3 - constructive engagement

These "phases" are probably quite representative of what municipalities, other forms of governments and health care systems experience. We believe that the VA, although the system is affected differentially as pointed out above, has embarked on its own constructive engagement phase.

In terms of planning for the future, the following concerns or actions occupy our attentions.

(1) Continue to cooperate with other Federal agencies (DoD, DHHS, etc.).

(2) VA internal cost accounting and reimbursement methodology are under continuing review.

(3) The feasibility or desirability of identifying "AIDS Centers" in medical centers located in the epicenters of the epidemic.

(4) Continuation of the zidovudine (AZT) clinical research trial in patients with ARC.

(5) Education remains a key ingredient in any program designed to reduce the spread of this life-threatening infection. It also must be continuing, current and targeted for specified audiences.

STATEMENT

J. JARRETT CLINTON, M.D.

DEPUTY ASSISTANT SECRETARY OF DEFENSE
(PROFESSIONAL AFFAIRS AND QUALITY ASSURANCE)
OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

HUMAN IMMUNODEFICIENCY VIRUS

before the

Committee on Veterans' Affairs
United States Senate
100th Congress

June 24, 1987
9:30 a.m.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

It is my pleasure to appear before you today to discuss the Department of Defense policy on Human Immunodeficiency Virus (HIV). First, I will provide an overview of the current status of our program including serologic test results, medical evaluation program, research initiatives, and educational efforts. I will then review the revised DoD policy on HIV/AIDS issued by Secretary Weinberger on April 20, 1987.

CURRENT STATUS OF PROGRAM

Results of Testing

The Department of Defense recruit applicant screening program began in October 1985. As of March 1987, the Department has screened more than 958,600 civilian recruit applicants with 1454 individuals identified with serologic evidence of HIV infection. This is an overall antibody prevalence rate of 1.5 per thousand, a rate that has been constant during the testing program. Statistical synopses of this information, including geographic specific prevalence rates, are periodically provided wide dissemination through the U.S Public Health Service's Morbidity and Mortality Weekly Report (the most recent report attached). State specific information is provided quarterly to each state health officer by the Centers for Disease Control.

this provision would codify and enhance an existing facility, the National Veterans' Training Institute, which is located in Denver, Colorado, and set up by the Assistant Secretary for Veterans' Employment and Training. We defer to the Department of Labor for comment on this section.

Section 8 of S. 999 would require the VA to mandate that each VA regional office provide to appropriate public employment service offices and Department of Labor offices, as designated by the Secretary of Labor, a listing. This listing, on a monthly or more frequent basis, would include the names and addresses of employers who offer an approved program of job training under the VJTA.

Mr. Chairman, we have no problem with such notification and make notifications now on new and amended approvals.

Mr. Chairman, for the reasons previously stated, the Administration opposes extension of the VJTA; accordingly, we oppose section 9 which would amend that Act. However, we would appreciate the opportunity to provide a written analysis of such amendments at a later date.

Mr. Chairman, you have also asked for our comments on S. 918, the proposed "Veterans' Educational Assistance Improvements Act of 1987," which you introduced on our behalf on April 3, 1987. Title I of this measure contains a number of changes to our educational programs; title II would repeal the Agency's authority to make education loans to veterans and other eligible persons; and title III contains a savings provision relating to the repeal of the education loan program.

The measure would amend the New GI Bill-Active Duty (chapter 30 of title 38, United States Code) to authorize a 2-week period after the date of an individual's initial entry on active duty within which that individual may elect not to receive chapter 30 education benefits. Currently, the law is unclear as to how much time the individual actually has to make this election after entry on active duty. Unless an affirmative election not to participate is made, the individual automatically becomes a participant in the New GI Bill program. We believe that a 2-week period from entry on active duty should be allowed for making this important decision.

S. 918 would also eliminate authorization for advance payment of subsistence allowances under chapter 31 to certain eligible veterans. These advance payments are intended to assist veterans in paying a portion of tuition and fees required prior to commencement of training, as well as to help to meet living expenses during initial periods of training. However, since the VA already pays all of a chapter 31 participant's training costs and since the participant is also eligible for advances from the Revolving Fund under section 1512 of that chapter, additional advance payments under chapter 31 are not justified. These advance payments also result in increased overpayments in some cases.

Under current law, an individual participating in the veteran-student services program is entitled to receive an advance payment equal to 40 percent of the total payable under his or her work-study agreement. Upon completion of the work specified in the agreement covering the advance payment, the individual receives payment of the remainder on an incremental basis. Unfortunately, this provision has engendered overpayments, totaling $637,129 during Fiscal Year 1986 alone. Collection often is not feasible because the debtor has dropped out of school. Moreover, the relatively small size of each individual overpayment makes its enforced collection generally not cost-effective. S. 918 would eliminate the provision for advance payment of the work-study allowance to the veteran-student.

The bill would also amend chapter 36 of title 38 to provide that, for purposes of measuring training time, the term "standard class session" means 2 hours or "two fifty-minute periods" of laboratory instruction. In the main, institutions of higher learning have modified their periods of instruction to 50 minutes for laboratory sessions. Under current law, however, a "standard class session" of laboratory instruction is defined only as 2 hours of such instruction. This can result in entitlement to payment for less than full-time training for pursuit of the 50-minute lab sessions, even though a veteran might be a full-time student, and has caused overpayments. The amendment would eliminate this problem.

The bill would amend the chapter 36 requirement for annual compliance surveys at each educational institution that offers one or more approved courses in which 300 or more veterans are enrolled, or which offers courses which do not lead to a standard college degree. This amendment would eliminate any reference to the numerical guidelines which currently exist and allow the Administrator to conduct compliance surveys at any institution whenever appropriate and in the best interest of the Government. In this manner, personnel can more effectively and efficiently be used where the need is greatest.

The bill makes a technical amendment to chapter 51 to require that award effective dates under chapter 32 correspond, to the extent feasible, with those for other programs.

Finally, as already noted, S. 918 would provide for the amendment or repeal of various sections of title 38 which authorize the VA to make education loans, including accelerated payments, to veterans and eligible persons. Notwithstanding this repeal, the Administrator would continue to collect the principal and interest on those loans which are outstanding, as well as any overpayments made under the program.

The VA education loan program has an excessively high default rate of 75 percent. In 1981, the Congress addressed the problem through greatly reducing the scope of the loan program. Since that time, the number of loans made has continued to decline, and we now believe that all authority of the VA to make education loans should be removed.

Additionally, provisions of S. 918 would rescind the VA's inoperative authority to make accelerated payments of educational assistance allowances. These accelerated payments were made contingent upon the states' establishment, before November 24, 1982, of programs which would pay the VA amounts which matched these accelerated payments. No state complied with this matching fund requirement and the program has now expired.

Technical amendments within this bill would delete all title 38 references to education loans consistent with the foregoing paragraphs. However, the "Veterans' Administration Education Loan Fund" would continue to be maintained in the U.S. Treasury to allow continued use of the education loan program's existing accounting system. The Administrator would be authorized to transfer all or part of these monies to the appropriation for readjustment benefits as necessary for the purposes of that account.

We appreciate your introduction of our bill, Mr. Chairman, and urge the Committee's favorable action on S. 918.

Mr. Chairman, that concludes my formal statement. I would be pleased to respond to any questions you or members of the Committee may have.

STATEMENT OF DONALD E. SHASTEEN
ASSISTANT SECRETARY FOR
VETERANS' EMPLOYMENT AND TRAINING
BEFORE THE
UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

April 30, 1987

Mr. Chairman and Members of this Subcommittee:

Thank you for this opportunity to appear today to discuss legislation to amend Chapter 41, Title 38 United States Code, S. 999, the Veterans' Employment, Training and Counseling Amendments of 1987.

Mr. Chairman, we believe that the increased costs and reporting burdens of several of the provisions of S. 999 outweigh any benefits that would be gained. There are, however, measures which we support and believe are beneficial to veterans seeking jobs or training and which will not significantly increase our cost or require legislation.

We oppose section 3 of the bill which would significantly increase the number of Local Veterans' Employment Representatives (LVERs) and the budget required to support them. This section would result in distributing positions based on resident population rather than workload. Also, it appears that these amendments would result in the Federal government directly intervening into state personnel performance reviews and administrative management activities of State operations.

The formula proposed would require one LVER for each local employment service office at which 1,000 veterans were registered during the 12 month period ending on this most recent June 30, or which has a service area in which 5,000 veterans reside. One additional LVER would be required for each additional 1500 veterans registered or 5,000 veterans residing in the service area, whichever results in the assignment in the greater number of LVERs. For every local office that has less than 1,000 veterans registered or fewer than 5,000 veterans residing in the service area, part-time LVER would be assigned in proportion to the full-time LVERs formula.

There are over 2,000 Job Service Offices located throughout the United States; many particularly in metropolitan areas, do not have well defined service area boundaries. Applicants frequently visit a local office based upon the quality of service and types of jobs available at that office rather than their residential proximity to a local office.

Therefore, it would be difficult, if not impossible, to accurately count the number of veterans residing in a local office service area since these areas do not conform to census boundaries. Reliable population estimates do not exist now, would be costly to produce, and would require many months to develop.

Another problem in using veterans population as a factor in the LVER formula is that population is not a good micro-measure of the demand for employment services or individuals' attachment to the labor market. That is, whereas one may assume with a high degree of certainty that where hundreds of thousands of veterans reside there is a general need for services, there is no data that strongly supports the supposition that where there are a few thousand residents there is need for the specific services of an LVER. Indeed, using the number of veterans residing in a service area can disproportionately inflate the number of LVERs in favor of states with large populations of retired veterans.

For these reasons, I believe the formula must be based on workload and not populations. Furthermore, I believe that the current and projected assignments of LVERs is adequate to meet the mandates of Title 38. Our local office evaluations suggest to us that the support of the concept of priority for veterans by State agency management is a more significant contributor to the employment of veterans than is the number of LVERs assigned.

Mr. Chairman, Section 4 of the proposed amendments requires that an Assistant State Director Veterans' Employment and Training Service (ASDVETS) formally participate in the LVER performance appraisal process. We believe that such involvement in State agency merit system practices is impractical and would not result in improved services to veterans. SDVETS and ASDVETS currently monitor local office activities and review LVERs performance. Their evaluation reports contain good indications of whether or not LVERs are performing satisfactorily, and may be used by an LVERs supervisor in the rating process. We believe that the annual performance rating is a State agency management function, should not be the responsibility of the federal government, and joint responsibility is unworkable.

The provisions of section 4 which would require the development and implementation of specific standards of performance for DVOP and LVER staff, however, are positive in intent and could be carried out successfully. Without introducing direct Federal involvement in the evaluation process of individuals, we propose to develop prototype standards and tailor them to meet each State's merit system requirements through negotiation with our State Directors Veterans' Employment and Training Service. This goes one step beyond our current grantor-grantee relationships, and is a feasible approach to ensuring program quality through individual DVOP and LVER performance.

Section 5 requires the Secretary of Defense to provide to the Secretary of Labor a current list of the employers participating in the National Committee for Employer Support of the Guard and Reserve and thereafter monthly updates. To be useful this information would need to be broken down to state and substate areas. Generally, this information is available to the Veterans' Employment and Training Service staff at the local level, and therefore we do not see the need for this provision. I am sure the Department of Defense would cooperate in providing such lists if requested by the Secretary.

Section 7 of the amendments requires the establishment and operation of a national training institute to train DVOP, LVER, and State and Assistant State Directors for VETS staff in the provision of employment, job training, placement, counseling, or related services to veterans. This provision is unnecessary.

As you know, the VETS operates, through a grant to the State of Colorado, the National Veterans Training Institute (NVTI), which trains DVOPs, LVER and other State agency staff to provide such services, following the "whole person" concept. One of our objectives in FY 1987 is to explore additional funding sources including other agencies and veterans programs. The states voluntarily send their staff to this training which helps to ensure high quality and uniformity in the delivery of national veterans employment programs by the 52 state entities.

Mr. Chairman, section 9 concerns itself with the Veterans Job Training Act (VJTA). I understand what the committee is endeavoring to accomplish. However, as I indicated in testimony before the House of Representatives Committee on Veterans Affairs on March 18, I believe that this program which was to address the extraordinary levels of severe and continuing unemployment among Korean and Vietnam veterans has accomplished the purpose for which the legislation was enacted. The month prior to the enactment of EVJTA, the unemployment rate (not seasonally adjusted) for all Vietnam veterans was 9.1% while that for non-veteran adults in the same age span was 8.4%. Today the picture has improved considerably. The most recent data (March, 1987) shows that while the Vietnam veteran unemployment rate was 5.5% the unemployment rate for non-veterans in the same age group was 5.6%. We therefore feel that this program is no longer necessary to address the level of unemployment among veterans. In addition, the added reporting burden on the States required by this section would be expensive and difficult to implement within the required time frames. For these reasons, and because of the recent legislation proposed by the Administration that will serve unemployed veterans as well as other dislocated workers, the Administration is not requesting or recommending that the VJTA program be extended.

Mr. Chairman, as I stated earlier in my testimony, I believe there are some actions that we can take that are consistent with this proposal which would strengthen implementation of Title 38, such as the addition of counseling to the service provided by LVERs and DVOPs. I believe we have to ensure counseling is available at the local office. I believe that properly trained DVOP and LVERs can provide this service. For this reason I have directed the development of a counseling module at the National Veterans Training Institute. We can do this within current law and budget and this will provide the improved service to veterans that these amendments are seeking.

Once again, thank you Mr. Chairman for allowing me to express my views regarding the proposed Veterans' Employment and Training Amendments of 1987.

Testimony of Mr. Augustin Hernandez

Before the Senate Veterans' Affairs Committee

April 30, 1987

Mr. Chairman, it is my privilege to appear before the distinguished members of this committee to comment on veterans training and employment.

I am Augustin Hernandez, owner of Hernandez Electric Company of Phoenix, Arizona. The firm operates as an independent electrical contracting company. As an electrical contractor I am involved on a daily basis with the employment of skilled and unskilled workers and their training. It is from this perspective that I make my remarks. I have employed 11 veterans under the Veteran Job Training Act (VJT) and currently have four working, all of whom have been promoted and are in lead positions. In addition, several veterans have been able to gain higher paying jobs within the industry as a result of VJT training with my company.

My testimony will focus on two distinct aspects of veterans employment and training; first, the need to continue and to improve the VJT program and second, the improvement of the support structures for VJT.

Primary to any business venture is the need for operating capital. VJT has run short of money. This has caused delays in payment and a slowdown in recruiting veterans into VJT. This in turn has led to reticence on the part of employers to use VJT. With the $30 million in the basic bill, the first remedial step has been taken. The amendment for additional funding offered by my Senator, Mr. DeConcini, and co-sponsored by you, Mr. Rockefeller and Mr. Matsunaga will add considerably to the assurances business people need to "buy" back into the program.

In order to improve the success rate of veterans completing training and remaining on the job, communication between the employer and veteran must be enhanced. Both the veteran and the employer have to be aware of each other's needs. All too often, minor misunderstandings erupt into dismissal of an employee or an employee's quitting. Both situations may possibly have been prevented by the two parties talking to each other. In the bill, job counseling and case management are key points. I would suggest they are critical points. Job counseling must be two-fold. It must occur both before employment but more importantly, during post-employment follow-up. The veterans' representative needs to know more than cursory information about the veteran and employer in order to conduct in-depth discussions. The case management system makes this possible. Then, if the veterans' representative makes meaningful periodic follow-up visits to employers, unnecessary dismissals or quits could be prevented.

The LVER/DVOP must have the training to recognize the various situations and have the skill to mediate between the participants. I strongly support the training of veteran staff in those inter-personal relations that enables them to be both a good monitor and mediator. A national institute for counselor training would insure that veterans' representatives will receive a uniform curriculum that is broad in scope. Also, the institute would allow student exposure to resources which might not be available to individual state training programs.

The second aspect I want to emphasize is the improvement of support structures for the VJT program. In addition to training, I endorse the change requiring that the LVER be a veteran. In many areas, especially in small communities, the LVER is considered to be the veterans' advocate on a host of issues including employment and training. In these locales, the strongest supporters for veterans are the veteran service organizations. While non-veterans may be allowed access to the organizations, they are not readily or completely accepted whereas the veteran is easily accepted.

I support the additional LVER positions for metropolitan areas as long as the smaller and rural offices are not adversely impacted. We need to make sure that if a reduction in the veteran staff becomes necessary, the smaller or rural offices would not be eliminated at the expense of the larger metropolitan staffs.

I recommend the emergency clause for service to non-veterans by a LVER be placed back in the bill. This would allow the LVER in a small office to assist unemployed workers when an emergency occurs. Let me illustrate. In Sierra Vista, Arizona, the Job Service office has a staff of four. There is one Manager, one LVER, one DVOP and one non-veteran staff. Under your bill, if the manager and non-veteran staff member were unavailable, due to an emergency, there would be no one to assist the non-veteran unemployed worker. A solution could be to allow the LVER to service these clients after assisting the veterans and to charge the time to appropriate non-veteran programs.

In conclusion, I thank you again Mr. Chairman, not only for this opportunity to address you but to commend you for your leadership in the establishment and continuation of the VJT program and for the total support both you and Mr. DeConcini have given all veterans' programs.

STATEMENT OF JAMES N. O'BRIEN
DIRECTOR, HUMAN RESOURCES STAFFING
MCDONNELL DOUGLAS CORPORATION

Before the

SENATE COMMITTEE ON VETERANS' AFFAIRS

April 30, 1987

Mr. Chairman, McDonnell Douglas thanks you and the entire Senate Committee on Veterans' Affairs for giving us the opportunity to present our views on S.999 and proposed legislation to authorize FY 1988 and 1989 appropriations for the Veterans' Job Training Act (VJTA).

Mr. Chairman, you and Senator Alan Simpson as Senate co-authors of the original VJTA legislation deserve credit for defining a much needed veterans' program that truly works. We would like to share with you our own experience with this outstanding program and the nature of the training and employment opportunities created through VJTA for long-term jobless Vietnam-era and Korean Conflict veterans. Before we do so, McDonnell Douglas would like to reaffirm to this Committee our strongest support for VJTA. We believe that VJTA is a model program and that other government agencies could learn much from VJTA. In particular, the program provides worthwhile financial incentives to employers for training and employing a well defined and especially deserving group of Americans. VJTA does this without imposing any arbitrary red tape or administrative procedures on the employer.

McDonnell Douglas first became actively involved with VJTA in 1985 when the company made a corporate wide commitment to the VJTA program. McDonnell Douglas has always supported the priority hiring of veterans. After reviewing the VJTA legislation, we decided that this would further enhance employment and training opportunities for veterans -- especially those from the Vietnam era -- at McDonnell Douglas.

The decision to implement VJTA at McDonnell Douglas facilities around the nation came only after considerable input was received from operational managers at the company's manufacturing facilities. McDonnell Douglas' first commitment, as you can appreciate, is to the timely and cost effective delivery of the best military and commercial systems possible for our nation and the rest of the world. VJTA could only be implemented if it supported this priority.

In meetings with our managers around the country, the Corporate Human Resources staff repeatedly heard the same questions about VJTA. Would VJTA impose a separate set of rules and regulations upon the company's operations? Would VJTA impose burdensome reporting requirements on the company? Would VJTA require the company to pull workers off the production line and negatively impact the work of many other people? Would VJTA single out participants in such a way as to attach a stigma to the program and the people in the program? And finally, would the benefits of the program justify the cost of participating in the program?

With input from our Human Resources consultants, Management Insights, Inc. (MII), on the many positive aspects of the program and our belief that VJTA would not interfere with company operations, McDonnell Douglas embarked upon what would soon become one of the most successful training and employment programs ever initiated by the company.

Last year the Veterans Administration recognized McDonnell Douglas' efforts in hiring veterans through VJTA -- 215 as of the date of the award. Our records now show that 296 veterans have participated in McDonnell Douglas' VJTA program.

S.999 will help to strengthen an already outstanding support system for veterans' job counseling, training and placement. McDonnell Douglas would like to personally express its gratitude to the many Veterans Employment Representatives and Disabled Veterans Outreach Program Specialists whose hard work and dedication have helped make our own program so successful.

McDonnell Douglas strongly supports virtually all of the provisions of S.999 including restructuring the veterans support organization to make it even more responsive and more focused on veterans' needs, assigning staff to areas of greatest need, establishing uniform performance standards, providing more timely and complete information on training and employment opportunities, helping to clarify the mission of Employment Service personnel regarding veterans, and improving the quality of training for veterans' support staff.

We are, however, concerned about the proposed change in the payment schedule from 50% of trainee's wages to a staggered payment scheme that delays payment beyond program completion. A change to the proposed 30/50/20 payment system would add to reporting requirements for all trainees and complicate the invoicing process by attaching a different payment percentage to each month of payroll. Moreover, this change would reduce payments to even the most successful employers in the VJTA program since there will always be some noncompletion. As a result, we believe that this change would actually reduce the financial incentive to participating in the program and work against the veterans most in need of training and employment, i.e., those with the greatest disabilities and the most time out of work and, therefore, the most likely to not complete training. It should also be noted that all veterans in the program receive some work and training and break the cycle of unemployment.

Probably an even more direct approach to increasing training completion can come through controls already wisely built into VJTA. Prior to hiring and training eligible veterans, an employer must first develop a description of its training program and receive formal approval from the Veterans' Administration. This process makes it possible for the VA to screen out any training programs or employers that do not benefit veterans.

One of the difficulties in evaluating the need for changes to VJTA is the lack of a readily available database on the impacts of the program. McDonnell Douglas is currently in the second phase of a study by our Human Resources consulting company, Management Insights, Inc. (MII), to better quantify the types of applicants, their previous salary history, their length of unemployment, and their success in our program. Although the results are still in a very preliminary stage, we are pleased to note that our completion rate for VJTA training is approximately 84% -- far in excess of the numbers reported in the Centaur study. This is even a more remarkable percentage given the fact that training at McDonnell Douglas is often for highly-paid, skill-intensive jobs that will provide long-term careers for veterans.

We are also concerned about the proposed assignment of a "case manager" to each veteran and the requirement that they become responsible for helping the veteran resolve any problems encountered in training. Although we support the intent of the legislation, we are not at all clear about how it would be implemented. We believe that the employer and trainee need to be the focal point of any counseling regarding on-the-job training and performance on the job without unnecessary intervention by third parties. We would have difficulty in convincing our managers and supervisors otherwise.

Mr. Chairman, the proposed legislation authorizing FY 1988 and 1989 appropriations for VJTA is vital to the continued success of the program. We at McDonnell Douglas have made a special effort to integrate VJTA directly into our hiring process. Veterans are referred to McDonnell Douglas by various veterans' organizations and by veterans' representatives in the Job Service system. McDonnell Douglas also regularly sends employment representatives to job fairs sponsored by these organizations. Most of the veterans screened by us are long-term unemployed or disabled veterans.

We also post signs in our employment lobby instructing veterans with a Certificate of Eligibility for the VJTA program to alert the employment representative of this fact. The representative attaches a copy of the certificate to the veteran's application and stamps the application with a "V" to alert all interviewers of the veteran's VJTA-eligibility. Interviewers include this as a factor to be considered when making hiring decisions.

Veterans who have questions concerning the program are referred to a Job Service veteran's representative. McDonnell Douglas keeps in constant communication with the Job Service representatives to inform them of job openings. The representatives work with our employment representatives in determining how to pre-screen applicants.

The process does not end with the hiring offer. Each VJTA-eligible veteran is contacted on a regular basis to determine his/her training progress and to sign Completion of Training forms required by the VA. A local Job Service veterans' representative is always available to answer any questions veterans may have concerning the program.

Here is a real life example of how this program has been very successful, both for McDonnell Douglas in its efforts to recruit veterans and for veteran trainees who have learned new skills. Jim Rodriguez (we have changed the names of veterans mentioned here to preserve their privacy) was referred by a veteran's representative at the California Employment Development Department to McDonnell Douglas' Long Beach plant on October 15, 1986. Jim had been unemployed for almost two years; his previous job experience had been mainly as a security guard making less than $6.00/hr. At the time of his interview, Jim presented his VJTA Certificate of Eligibility to the McDonnell Douglas interviewer. He was hired on November 10, 1986 as an aircraft assembler making $9.01/hr.

He had been on the job only one month when his training supervisor decided that his progress in training was not satisfactory. Fortunately for Jim, his supervisor, following McDonnell Douglas' policy, reviewed his background to determine if he could be placed in another VJTA-approved position. Within three days he was placed in a new position as a material coordinator. Jim is still performing well in that position. Thus, the VJTA program worked twice for Jim.

Veterans such as Jim are normally hired into one of over 100 VJTA-approved positions. These positions are mainly hourly positions such as aircraft assembler, electrical assembler, and security officer but also include positions such as tape librarian, manufacturing service representative, and fabrication inspector. The starting wage for these positions ranges from $6.82/hr. to $14.63/hr. with an average starting wage of $9.04/hr.

Here is another example of how the program works at McDonnell Douglas. Arthur Hopkins was a Vietnam-era veteran who remained in the military until February, 1985. After his discharge, he spent three months unsuccessfully looking for employment until a Job Service veteran's representative informed him of the VJTA program and referred him to Douglas Aircraft on May 31, 1985.

Arthur informed the employment representative of his VJTA-eligibility and was hired within two weeks as an electrical assembler. Like Jim Rodriguez, Arthur was unable to successfully complete his training but a new position was found for him as a painter helper. He is still performing well in that position and readily admits how much he owes his employment to the VJTA program.

The program has also created outstanding training and employment opportunities for disabled veterans. Fred Martin, a disabled veteran, was laid off from his job as a dispatcher at a car dealership in December of 1984 after he had been out ill with a prolonged illness. He had been out of work for six months when he was referred by the Job Service to Douglas Aircraft in May of 1985. Fred was hired by McDonnell Douglas in June of 1985 as an aircraft assembler and was able to complete his training program. After his training program, he was promoted to the position of Engineer/Scientist, a position he still holds at Douglas Aircraft.

To conclude, McDonnell Douglas expects to have thousands of full-time openings during the next year, many of which can be filled by long-term jobless Vietnam-era veterans in VJTA approved positions. If the program is extended, we will continue our policy of priority hiring of VJTA-eligible individuals who meet the qualifications for these positions.

3828e

TOWN & COUNTRY ELECTRIC, INC.

TESTIMONY OF RONALD L. SAGER SUBMITTED TO THE UNITED STATES SENATE COMMITTEE ON VETERANS' AFFAIRS, WASHINGTON, DC 20510-6375 on APRIL 30, 1987.

Mr. Chairman it is a privilege for me to appear before your distinguished Committee and present my views concerning S. 999. My name is Ronald L. Sager and I am the Manager of Human Resources at Town and Country Electric, Inc., Appleton, Wisconsin, an electrical contracting firm that employs 121 personnel of which approximately 42% are veterans. We have received numerous awards for hiring veterans of which the last award we received was from the U.S. Department of Labor in November of 1986 for hiring disabled veterans. Prior to my position with Town and Country Electric, Inc., I was for five years and six months, a Disabled Veteran Outreach Program Specialist (D.V.O.P.) for the Wisconsin Job Service. I worked developing veteran job training (V.J.T.) sites for many eligible veterans. As an 80% combat disabled veteran I can relate to problems and concerns the veteran and their families have encountered relative to securing gainfull employment. During my time on the D.V.O.P. Program, I had counseled literally hundreds and hundreds of veterans in employment and training matters. Corollary to this I became involved in many support type organizations such as the Veterans Administration (V.A.), Wisconsin Department of Veteran Affairs and the Disabled American Veterans (D.A.V.). In 1983, I received the National Award as the outstanding D.V.O.P. in the United States.

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Being a Human Resources Manager for the past three years I now feel I have a more complete perspective relative to employment problems of veterans. I also feel a great deal of urgency relating to the pending legislation of Senate Bill S. 999. I would at this time like to briefly discuss from an actual case history relating to one of our own veteran employees that was on the V.J.T. Program. We hired a veteran under V.J.T. in September 1985. This veteran was very eager to work for our Company as an electrical assistant with the knowledge of going on for a four year electrical training program (Vocational School and on the job training) to become a licensed Journeyman Electrician. His work during the next four months was very good. However shortly into the 1986 new year his performance, work habits and attitude as reported by his Supervisor had changed significantly in the negative sense. After a certain amount of individual employer/employee talks, his behavior on the job had not changed. I confronted him again with this problem and that is when he broke down and related his problems of not being able to handle the job, ongoing psychological trauma relating to adjustment in society (he was a member of the U.S. Air Force Operation Ranch Hand Project in Vietnam) and family discord. I referred this veteran to a private psychologist approved by the V.A. Town and Country Electric, Inc. kept this veterans medical insurance in force and contributed monies for his personal treatment. We then after a few weeks referred this veteran, when it was evident he could no longer work in our trade, to the Wisconsin Department of Vocational Rehabilitation since he was not eligible for Chapter 31 benefits under current V.A. regulations. Town and Country Electric, Inc. clearly understands, based on the case history I have just briefly outlined, that as far as the veteran is concerned there are frequently needs that supercede the need for a job. Therefore I strongly urge passage of S. 999 to provide the very critical element of support and follow-up of the veteran trainee so that these individuals realize long-term gainfull employment opportunities.

In conclusion Mr. Chairman I would like to emphasize that as a person who has placed veterans into V.J.T. Programs, as an employer who has hired veterans under V.J.T. and as a disabled veteran who has been through V.A. Vocational Rehabilitation, I cannot reiterate strongly enough the necessary relationship between career counseling, psychological counseling, training and follow-up support services for all V.J.T. participants. This would address the problem of early noncompletion of V.J.T.'s and provide ongoing support such as career counseling to help veterans select the appropriate career field, psychological counseling to address their personal needs and a case manager for continuous support to insure success during the training period. In essence this would promote the success that this V.J.T. Program was originally set up to do by previous Legislation. Mr. Chairman, I would also like to address the issue of accountability for this program. Although functional supervision should remain with the Job Service office, overall performance standards should be monitored by an aggressive and committed State Director of Veterans Employment and Training Service. This individual should be answerable to the Office of the Assistant Secretary for Veterans Employment and Training. This should not be a numbers game of just throwing dollars in Veterans employment benefits but rather a concerted effort to implement both a training program and a reasonable support program. Additionally, I would like to recommend that the Amendment to allocate appropriations of $60 million over and above the $30 million for each of fiscal years 1988 and 1989 be approved.

Thank you Mr. Chairman and distinguished members of this committee for allowing me this opportunity to express my convictions relating to S. 999 and its amendment.

Signed:

Ronald L. Sager

Ronald L. Sager

STATEMENT OF

DR. ROBERT E. DAVID
EXECUIVE DIRECTOR

SOUTH CAROLINA EMPLOYMENT SECURITY COMMISSION

TO

SENATE COMMITTEE ON VETERANS' AFFAIRS

APRIL 30, 1987

Mr. Chairman, members of the Committee, my name is Robert E. David. I am Executive Director of the South Carolina Employment Security Commission. I appreciate the opportunity to participate in this hearing concerned with improving employment and training services to those who have so faithfully served our country.

As a veteran myself, and an individual who has been directly responsible for administering state and federal programs for those in need, I applaud your efforts to better serve our nation's veterans through the introduction of S.999.

In my opinion, men and women who offer their lives in the service of our country cannot be treated too kindly upon return to civilian life. However, of all the programs and benefits that may be available to our veterans, employment assistance is possibly the most over-looked and under-rated.

Mr. Chairman, when you introduced S.999 before the full Senate on April 9, you recognized how important it is to guarantee veterans access to uniform employment services everywhere in this nation; and your commitment to improving our system for delivering services is deeply appreciated by all who care.

First of all, I fully support this proposal's intent to insure that there is an adequate number of LVERs and an adequate number of DVOPs to get the job done. You are correct, I believe, in choosing a formula which takes into account several factors in determining actual positions. Most veterans, when they retire, pursue second careers and need counseling perhaps and job-finding assistance; therefore, the number of veterans residing in a given area is a valid measure. At the same time, the number of veterans registered with the Employment Service also is a valid indication of how many individuals may be seeking service. Neither factor alone tells the true story, but taken together, they do provide a fairly accurate picture.

We should, however, be very careful in our final determination of formula elements; but I am in full support of a more expanded approach than is now utilized. The best feature in the proposal, however, is the guarantee that adequate staff will be provided with some degree of stability. That, Mr. Chairman, is a problem that has afflicted the entire employment security system in recent years --- budgets being yo-yo-ed up and down without regard to workload or needs. If this bill can bring stability to the staffing of the Employment Service for veterans' programs, then you will have done the veteran, the system, and the nation a very great service.

Before moving on to my next area of concern, I'd like to express my support for the establishment of a National Veterans' Employment and Training Service Institute as incorporated in your bill. If enacted, this would provide the type of accredited facility that could enhance existing skills, teach new ones, serve as a technical exchange for new ideas in service delivery and, overall, enhance the pride in service for those specialists whose job it is to assist veterans in the labor market. In this regard also, I would hope that other ES personnel--those who are not LVERs or DVOPs but also provide services to veterans and others--could be specifically cited in the final bill as being permitted to participate in Institute training.

It is my understanding that Assistant Secretary of Labor Donald Shasteen has already done an excellent job in developing training facilities out in Denver, known as the National Veterans' Employment and Training Service Institute. After all, training does make sense. We insist on the very best training for our military personnel; doesn't it follow that the kind of service we render in the area of employment assistance and counseling will depend on how well trained our specialists are?

There are so many good features in this legislation, Mr. Chairman, that I find it hard to say anything unfavorable. At the same time, I would be less than honest and not the best witness if I did not point out a couple of areas where problems could arise.

I mentioned the need for adequate training a moment ago. If we pursue comprehensive counseling programs and a system of case management, as proposed, we are increasing our commitment of staff and time. I would simply suggest that perhaps we should make sure that adequate funding would be forthcoming to meet these needed goals. Let us not forget that counseling requires training and we are dealing with people's lives.

Finally, as you know, the Employment Service has proved itself over the years as the nation's best delivery system for veterans' employment and training programs. During the past 12 years and more, it has been my privilege to manage a state employment security program, which has included a very successful veterans' component. Much of the credit, of course, goes to my good friend and valued associate, Bill Plowden, the first Assistant Secretary for Veterans Employment and Training.

Let me also briefly mention that, in general, the proposed changes to the VJT Program are greatly needed and should result in a stronger Program, especially for those veterans who need that additional level of support while participating. I am particularly impressed with the case manager approach, and, of course, the emphasis on counseling for individual participants.

The last item I wish to comment on concerns those sections of the bill which would make both LVERs and DVOPs functionally responsible to State Directors for Veterans' Employment and Training (SDVETs) and their assistants. I must admit that I am not certain what is exactly meant by the phrase "functionally responsible," especially since the measure recognized that LVERs and DVOPs are state employees, assigned by the administrative head of the Employment Service, and are directly supervised by ES managers. Unless this issue is clearly spelled out, there is the potential for conflict.

In this regard, I want to make it very clear that the SDVET should be concerned about the functioning of DVOPs and LVERs as well as appropriate service delivery issues. In South Carolina, I enjoy what I believe to be a productive and meaningful type of relationship with our SDVET. When there are issues of concern regarding staff, etc., we confer and resolve these matters as expeditiously as possible. The future relationship between State Employment Security Agency officials and SDVETS will, to a great extent, depend on the clarification of this matter, and I strongly recommend that your staff consult with other Employment Security Administrators about this issue.

Mr. Chairman, and Committee members, I want you to know that the veterans of our nation are indebted to you for your attention to these matters; and your commitment to a stable delivery system that serves their needs is deeply appreciated by those of us who administer the employment security system.

Mr. Chairman, that concludes my prepared remarks. I would be most pleased to respond to any questions that you may have.

TESTIMONY BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

WASHINGTON, D.C.

APRIL 30, 1987

BY

VINCENT RIOS

FORMER STATE SUPERVISOR

CALIFORNIA VETERANS JOB TRAINING

Mr. Chairman, Members of the Senate Committee on Veterans Affairs, Ladies and Gentlemen. I am Vincent Rios, Former State Supervisor for Veterans' Job Training Programs.

Mr. Chairman, I would like to thank you and the other members of the Committee for your leadership in addressing problems faced by the unemployed veterans.

Veterans Administration National Headquarters reports, as of April 1, 1987 California placements are 6,068 veterans with $23,389,223.00 encumbered. Compared to national overall placements of 47,692 veterans and $169,866,563.00 encumbered. California is ranking first among the other states in both number of placements and funds encumbered at 12 percent of national placements and 13 percent of national funds encumbered.

In addition, I wish to make the following specific brief comments about S.999:

Sections 2 & 3 of Senate Bill 999 provide for DVOP's and LVER's to be "functionally responsible" to the State and Assistant State Directors for Veterans' Employment and Training. There are 14 DOL staff in the State of California responsible for over 200 DVOP's and 100 LVER's. California now has a system of checks and balances with DOL.

California's DVOP Workload Summary Reports for the month of January and for the year-to-date through January indicate by the following table showing the percentages for non-veterans served by month, positive ongoing efforts to correct/eliminate reporting errors.

Services	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.
Registrations	4.8	4.8	4.6	4.0	2.5	1.3
Provided Services	4.3	4.2	4.3	4.2	3.4	2.1
Job Development Referrals	3.9	5.6	4.6	5.5	9.6	4.5
Referral to Job	5.4	5.6	7.0	6.9	5.6	4.4
Individuals Placed	6.8	8.1	7.8	8.0	6.8	5.1

Future improvement is expected as California field offices use the specific special printouts distributed to identify and correct remaining reporting problems. While the full impact of this effort will not be evident until the April reports are run, I expect to see continuing improvements during the intervening months.

California has had a degree of success thus far with the VJT program, but there are still many veterans unemployed and California continues to make every effort to place them through programs like the VJT.

That concludes my testimony. Thank you, Mr. Chairman.

federal register

TUESDAY, NOVEMBER 2, 1976

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PART III:

DEPARTMENT OF LABOR

Employment and Training Administration

■

PUBLIC EMPLOYMENT SERVICE SYSTEM

Services for Veterans

Title 20—Employees' Benefits

CHAPTER V—EMPLOYMENT AND TRAINING ADMINISTRATION, DEPARTMENT OF LABOR

PUBLIC EMPLOYMENT SERVICE SYSTEM

Services for Veterans

Notice is hereby given that the Department of Labor, Employment and Training Administration is amending 20 CFR Chapter V by implementing final regulations governing services to veterans by the public employment service system. The regulations are promulgated under 38 U.S.C. Chapters 41 and 42 and under the Wagner-Peyser Act of 1933, as amended, 29 U.S.C. 49 et seq.

The Department published proposed regulations on January 30, 1976 at 41 FR 4702. Interested persons were invited to submit comments on the proposed regulations until March 1, 1976. The Department received several dozen comments. The most significant comments, and the Department's responses thereto are listed below:

1. Most of the State employment service agencies objected to the mathematically stated performance standards set forth at § 605.25 of the proposed regulations. Under the proposed performance standards, as a general rule, if a State agency's statistically measured ratio of services for veterans did not exceed its statistically measured ratio of services for nonveterans, the State agency would virtually automatically be held to be out of compliance with the regulation. Many commentors stated that the proposed regulation was too mechanical and rigid, that it did not sufficiently allow for legitimate judgment factors, and that it did not take into account variables outside a State agency's control. Many commentors stated that, although the statistical "performance standards" might be very useful as indicators of State agency services to veterans, they did not themselves prove a State agency's performance to be necessarily good or poor.

In these final regulations, the Department has designated the statistical measurements as "veterans preference indicators of compliance". A State agency's failure to show up well on the statistical indicators will not itself put a State agency into the status of noncompliance. The State agency will first be given an opportunity to show cause for its apparently poor performance. In these final regulations, moreover, the standards of performance which a State agency must meet are the standards for actual services for veterans, such as standards for registration, standards governing priority in job referral, and standards governing the assignment of Local Veterans Employment Representatives.

2. Many commentors noted that, under the proposed regulations, a State agency which takes full applications on all applicants, and/or which serves veterans and non-veterans at a very high level, would have a more difficult time increasing its ratio of services to veterans over non-veterans than a State agency which traditionally has provided a lower level of services to veterans and non-veterans. For example, it would be far easier to increase placements from 5 out of 50 to 10 out of 50 than from 20 out of 50 to 40 out of 50. Yet, under the proposed regulations, both State agencies would show the same ratio of improvement. In the final regulations provision is made for establishing a "floor level" of performance for each State agency for each reportable service based on each State agency's past performance and other appropriate factors. Only after the floor level is established will the veterans preference indicators of compliance be applied.

3. Some commentors objected to the use of the term "handicapped veteran" noting, among other reasons, that, under various programs and statutes, DOL requires the use of more than a half-dozen different veterans' classifications. Some thought the term too ambiguous. Others objected to requiring an equal priority in services for veterans, who, though handicapped, did not have a service connected disability as for certain disabled veterans. In the final regulations, the term "handicapped veteran" has been replaced by the term "disabled veteran".

4. Many commentors objected to the requirement that veterans' job applications be reviewed every 10 working days. The final regulations change this requirement to every 30 calendar days to coincide with the automatic deactivation period already in use by State agencies.

5. Some commentors objected to the taking of full applications for veterans who are "job-attached". The final regulations state that full applications need not be taken for such veterans.

The final regulations also make several minor and clarifying changes and have been thoroughly edited and reorganized.

Accordingly 20 CFR Chapter V is revised, effective December 2, 1976, to read as follows:

PART 602—FEDERAL-STATE EMPLOYMENT SERVICE SYSTEM

1. The title of the Part 602 is changed to read as set forth above.

§ 602.1 [Amended]

2. In § 602.1 *Definitions.*, paragraph (g) is deleted.

3. Section 602.5 is revised to read as follows:

§ 602.5 Services for veterans.

Each State agency shall make services available for veterans pursuant to Part 653, Subpart C of this chapter.

* * * * *

PART 604—POLICIES OF THE UNITED STATES EMPLOYMENT SERVICE

4. Section 604.1, paragraph (d) is amended to read as follows:

§ 604.1 The placement process.

* * * * *

(d) To give priority in referral to veterans pursuant to Subpart C of Part 653 of this chapter.

* * * * *

5. Section 604.4 is amended to read as follows:

§ 604.4 Services for veterans.

It is the policy of the United States Employment Service to provide services to veterans as set forth at Part 653, Subpart C of this chapter.

* * * * *

PART 605—POLICIES OF THE SECRETARY OF LABOR [DELETED]

PART 653—SERVICES OF THE EMPLOYMENT SERVICE SYSTEM

6. Part 605 is deleted in its entirety.

* * * * *

7. A new Part 653 is added to read as follows:

Subpart A—Basic Services of the Employment Service System [Reserved]

Subpart B—Services for Migrant and Seasonal Farmworkers (MSFWs) [Reserved]

Subpart C—Services for Veterans

PURPOSE AND DEFINITIONS

Sec.
653.200 Purpose and scope of subpart.
653.201 Definitions of terms used in subpart.

FEDERAL ADMINISTRATION

653.210 Role of the Administrator.
653.211 Role of the Veterans Employment Service (VES).
653.212 Role of Regional Administrator (RA).
653.213 Assignment and role of Regional Veterans' Employment Representatives (RVERs).
653.214 Assignment and role of State Veterans' Employment Representatives (SVERs).

STANDARDS OF PERFORMANCE GOVERNING STATE AGENCY SERVICES TO VETERANS AND ELIGIBLE PERSONS

653.220 Standards of performance.
653.221 Standards of performance governing State agency services.
653.222 Performance standard on facilities for VES staff.
653.223 Performance standards on reporting.
653.224 Performance standards governing the assignment and role of Local Veterans' Employment Representatives (LVERs).
653.225 Standards of performance governing State agency cooperation and coordination with other agencies and organizations interested in the employment development of veterans and eligible persons.
653.226 Standards of performance governing complaints of veterans and eligible persons.

FEDERAL MONITORING OF STATE AGENCY COMPLIANCE

653.230 Veterans preference indicators of compliance.
653.231 Secretary's annual report to Congress.

AUTHORITY: 38 U.S.C. chapters 41 and 42; Wagner-Peyser Act, as amended, 29 U.S.C. 49 et seq.; sec. 104 of the Emergency Jobs and Unemployment Assistance Act of 1974 Pub. L. 93-567, 88 Stat. 1845.

Subpart A—Basic Services of the Employment Service System [Reserved]

Subpart B—Services for Migrant and Seasonal Farmworkers (MSFWs) [Reserved]

Subpart C—Services for Veterans

PURPOSE AND DEFINITIONS

§ 653.200 Purpose and scope of subpart.

(a) This subpart contains the Department of Labor's regulations for implementing 38 U.S.C. 2001–2008 (Chapter 41) which requires the Secretary of Labor to refer eligible veterans and eligible persons to employment and training opportunities through the public employment service system established pursuant to the Wagner-Peyser Act, as amended, 49 U.S.C. et seq.

(b) This subpart reiterates the requirement contained in the Department of Labor's Office of Federal Contract Compliance Programs' regulation under 38 U.S.C. 2012(a) at 41 CFR 60–250.33. 41 CFR 60–250.33, paragraphs (a) and (b), require State employment service agencies to refer qualified disabled veterans and veterans of the Vietnam era on a priority basis to job openings listed with them by certain Federal contractors pursuant to 38 U.S.C. 2012(a). Section 653.212(f), moreover, goes beyond the requirement of 41 CFR 60–250.33 by requiring State agencies to give priority in referral to qualified disabled veterans and veterans of the Vietnam era with respect to all job openings listed with the State agency's local offices.

(c) This subpart references the Department of Labor's Office of Federal Contract Compliance Programs' regulation under 38 U.S.C. 2012(b) at 41 CFR 60–250.26. That regulation provides that disabled veterans and veterans of the Vietnam era may file with Local Veterans' Employment Representatives complaints alleging violations of 38 U.S.C. 2012 or of the Department's regulations at 41 CFR Part 60–250. 41 CFR 60–250.26 also sets forth the procedures for handling such complaints.

(d)(1) This subpart partially implements section 104 of the Emergency Jobs and Unemployment Assistance Act of 1974, Pub. L. 93–567, 88 Stat. 1845. Sec. 104 of that Act requires the Secretary of Labor, in consultation and cooperation with the Administrator of Veterans' Affairs and the Secretary of Health, Education, and Welfare, to provide for an outreach and public information program to produce jobs and training opportunities for all persons who were discharged from the Armed Forces within four years of the date they apply for such jobs or job training.

(2) The Department has also implemented section 104 of the Emergency Jobs and Unemployment Assistance Act of 1974 in the regulations under the Comprehensive Employment and Training Act (CETA) at 29 CFR Parts 94–99.

(3) The Secretary has also implemented section 104 of the Emergency Jobs and Unemployment Assistance Act of 1974 by Secretary's Order 17–76, which establishes within the Department of Labor a Secretary's Committee on Veterans' Affairs, and which assigns to the Committee the following functions:

(i) Serving as the principal advisory and coordinating group to the Secretary of Labor on matters affecting veterans;

(ii) Consulting with and providing guidance to the appropriate DOL Agencies and the DOL Program and Budget Review Committee (PBRC) on the formulation, implementation and redirection of departmental policies and programs as they affect veterans, especially in the areas of unemployment, job training, employment and reemployment;

(iii) Reviewing the operational effectiveness of departmental plans and programs affecting veterans;

(iv) Facilitating DOL executive-level communications on veterans' affairs within the Department and with other governmental agencies, veterans' organizations, labor, management, and the Congress;

(v) Reviewing and suggesting research essential to the implementation of effective departmental programs on behalf of veterans; and

(vi) Coordinating the preparation of any reports to the Congress concerning veterans' affairs which involve the activities of more than one DOL agency.

(e)(1) This subpart also implements 38 U.S.C. Chapter 42 in the sense that Title IV of the Vietnam Era Veterans' Readjustment Assistance Act of 1974 amended 38 U.S.C. Chapter 41, section 2007 by adding a new subsection (b) which states:

> The Secretary of Labor shall establish definitive performance standards for determining compliance by State public employment agencies with the provisions of this chapter and chapter 42 of this title. A full report as to the extent and reasons for any noncompliance by any such State agency during any fiscal year, together with the agency's plan for corrective action during the succeeding year, shall be included in the annual report of the Secretary of Labor required by subsection (c) of this section.

(2) Since section 2012 of 38 U.S.C. Chapter 42 places responsibilities on State employment service agencies, this subpart prescribes performance standards for such agencies. The Department has also prescribed regulatory standards under 38 U.S.C. 2012 for such agencies at 41 CFR Part 60–250.

(f) This subpart references section 205(c)(5) of the Comprehensive Employment and Training Act of 1973 (CETA), as amended, 29 U.S.C. 801 et seq. Section 205(c)(5) requires that applicants for public service employment funds under Title II of CETA must provide the Department of Labor with assurances that they will give special consideration to unemployed veterans who served in the Armed Forces in Indochina or Korea on or after August 5, 1964.

§ 653.201 Definitions of terms used in subpart.

"Administrator, United States Employment Service (Administrator)" shall mean the chief official of the United States Employment Service (USES).

"Assistant Veterans' Employment Representative (AVER)" shall mean a Federal employee who is designated as an assistant to a State Veterans' Employment Representative (SVER).

"Director, Veterans Employment Service (VES)" shall mean the Department of Labor official who, under the Administrator, is the chief official of the Veterans Employment Service.

"Disabled Veteran" shall mean a person entitled to disability compensation under laws administered by the Veterans Administration for a disability rated at less than 30 per centum.

"Eligible person" shall mean:

(1) The spouse of any person who died of a service-connected disability;

(2) The spouse of any member of the armed forces serving on active duty who, at the time of application for assistance under this subpart, is listed, pursuant to 37 U.S.C. 556 and the regulations issued thereunder, by the Secretary concerned, in one or more of the following categories and has been so listed for a total of more than 90 days: (i) Missing in action, (ii) captured in line of duty by a hostile force, or (iii) forcibly detained or interned in line of duty by a foreign government or power; or

(3) The spouse of any person who has a total disability permanent in nature resulting from a service-connected disability or the spouse of a veteran who died while a disability so evaluated was in existence.

"Eligible veteran" shall mean a person who served in the active military, naval or air service and who was discharged or released therefrom with other than a dishonorable discharge.

"Local Veterans' Employment Representative (LVER)" shall mean an official in a local office of a State employment service agency, designated by the State Director to serve veterans and eligible persons pursuant to this subpart.

"Regional Administrator (RA)" shall mean the chief official of the Employment and Training Administration in each Department of Labor region.

"Regional Veterans' Employment Representative (RVER)" shall mean the Federal official designated by the Director, Veterans Employment Service, in each Department of Labor regional office who, under the RA, serves veterans and eligible persons pursuant to this subpart.

"Special disabled veteran" shall mean a person entitled to disability compensation under laws administered by the Veterans Administration for a disability rated at 30 per centum or more, or a person whose discharge or release from active duty was for a disability incurred or aggravated in line of duty.

"State Veterans' Employment Representative (SVER)" shall mean a Federal official, designated by the Director, Veterans Employment Service, who, under the RA and the RVER, serves the employment needs of veterans and eligible persons in a particular State pursuant to this subpart.

"United States Employment Service (USES)" shall mean the component of the Employment and Training Administration of the Department of Labor, established under the Wagner-Peyser Act of 1933 to coordinate a nationwide system of public employment service agencies.

"Veteran" shall mean "eligible veteran", "disabled veteran", "special disabled veteran", and "Veteran of the Vietnam era".

"Veteran of the Vietnam era" shall mean a person (1) who (i) served on active duty for a period of more than 180 days, any part of which occurred during the Vietnam era (August 5, 1964 through May 7, 1975) and was discharged or released therefrom with other than a dishonorable discharge, or (ii) was discharged or released from active duty for a service-connected disability if any part of such active duty was performed during the Vietnam era, and (2) who was so discharged or released within the 48 months preceding the person's application for employment under this subpart.

"Veterans Employment Service (VES)" shall mean the organizational component within the United States Employment Service which is concerned with policies and services relating to employment development on behalf of veterans and eligible persons.

FEDERAL ADMINISTRATION

§ 653.210 Role of the Administrator.

The Administrator, USES, shall have overall responsibility for administering this subpart and for monitoring, in coordination with other ETA components, State agency compliance with the regulations under this subpart.

§ 653.211 Role of the Veterans Employment Service (VES).

(a) The Director of the Veterans Employment Service (VES) shall monitor and evaluate the performance of the State agencies under this subpart. The Director, VES, shall make every effort, in coordination with the Veterans Administration, Department of Health, Education, and Welfare, other Federal and State agencies, educational institutions, unions, veterans organizations, and community groups to produce job and training opportunities for veterans and eligible persons through Department of Labor administered programs relating to unemployment, job training, and employment.

(b) The Director, VES, shall have a VES field staff comprised of Regional Veterans' Employment Representatives (RVERs), State Veterans' Employment Representatives (SVERs), and assistants to the SVERs (AVERs) and their staffs. RVERs, SVERs and AVERs shall provide functional supervision, guidance and assistance to the State agencies pursuant to this subpart.

§ 653.212 Role of the Regional Administrator (RA).

Each RA shall have overall responsibility in the region for administering this subpart and for monitoring State agency compliance with the regulations under this subpart.

§ 653.213 Assignment and role of Regional Veterans' Employment Representatives (RVERs).

(a) The Director, VES, shall assign an RVER to each Employment and Training Administration (ETA) regional office. Every RVER shall be an eligible veteran, who shall be appointed pursuant to the provisions of 5 U.S.C. which govern appointments in the Federal competitive service, and who shall be paid pursuant to the provisions of 5 U.S.C. Chapter 51, and Chapter 53 of subchapter III.

(b) Every RVER shall be stationed in an ETA regional office, shall, under the RA, be a member of the ETA regional executive staff, and shall be the regional representative of, and shall be administratively responsible to, the Director, VES.

(c) The RVER shall provide advice and expertise to the RA on matters relating to ETA services to veterans and eligible persons. The RVER shall also:

(1) Supervise the activities of all VES field staff within the region;

(2) Provide support for, and assist in the coordination of, all ETA policies and programs as they affect veterans, especially policies and programs relating to unemployment, job training, and employment by:

(i) Providing direction and support to SVERs and AVERs;

(ii) Reviewing SVER and other findings regarding State agency compliance with the regulations under this subpart and recommending appropriate corrective action to the RA;

(iii) Assisting other ETA regional office staff in the coordination of ETA employment and training programs as they affect veterans;

(iv) Coordinating within the region ETA activities relating to veterans' services with other agencies and organizations, such as the Department of Defense, the Veterans Administration, the U.S. Civil Service Commission, the President's Committee on Employment of the Handicapped, the Office of Vocational Rehabilitation and other Department of Health, Education, and Welfare agencies, labor unions, veterans organizations, employers and community organizations;

(v) Cooperating with the Employment Standards Administration of the Department of Labor in the resolution of complaints by veterans under the Department's regulations at 41 CFR Part 60–250; and

(vi) Monitoring and assessing unemployment, job training, employment and other services to veterans under ETA regulations.

(3) Monitor and evaluate State agency performance under this subpart by:

(i) Reviewing and analyzing monthly, quarterly and annual reports required by ETA data systems. RVERs shall compare actual services to veterans by each State agency by comparing the statistics generated by the veterans preference indicators of compliance set forth in § 653.230 against the performance standards set forth at § 653.221–26; and

(ii) With input from SVERs as appropriate, assisting the RA in conducting that portion of periodic and special reviews of State agency performance pertaining to the provision of services to veterans.

§ 653.214 Assignment and role of State Veterans' Employment Representatives (SVERs).

(a) A representative of the VES shall be assigned to each State agency to serve as the State Veterans' Employment Representative (SVER). One Assistant Veterans' Employment Representative (AVER) shall be assigned to each State agency per each 250,000 eligible veterans and eligible persons in the State population and additional AVERs shall be assigned whenever the data collected under this subpart indicates that additional AVERs are necessary.

(b) Each SVER and AVER shall be an eligible veteran, who, at the time of appointment, shall have been a bona fide resident of the State for at least 2 years, and shall be appointed pursuant to the provisions of 5 U.S.C. which govern appointments to the Federal competitive service, and who shall be paid pursuant to the provisions of 5 U.S.C. Chapter 51 and Chapter 53, subchapter III.

(c) The SVER, AVERs, and their VES Federal support staff shall be attached to the State office staff of the State agency to which they are assigned.

(d) Under the direction and supervision of the RA and the RVER, and in cooperation with the State agency staff and the staffs of other ETA funded employment and training programs in the State, the AVERs and SVER shall:

(1) Provide support and assist in coordinating all ETA policies and all ETA funded programs in the State as they affect veterans and eligibility persons, especially policies and programs relating to unemployment, job training, and employment.

(2) Functionally supervise services to veterans by the State agency. Functional supervision shall consist of assisting State agency personnel in carrying out services to veterans and eligible persons and evaluating their performance. Functional supervision shall entail providing technical assistance, making suggestions for improvement of services, helping to plan programs and projects, checking for compliance with ETA regulations affecting veterans helping to correct errors by working with local and State staffs, analyzing work as it affects veterans and eligible persons, training new State agency employees and providing refresher courses for State agency staff, bringing matters which require corrective action to the attention of those State agency personnel who have authority over policy, procedures and staff. Functional supervision does not authorize an SVER or AVER to hire, fire, discipline or issue directives to State agency employees. Nor does it authorize an

SVER or AVER to make regulations, change procedures or establish policies for the State agency without specific authority from the State agency;

(3) Engage in job development and job advancement activities on behalf of veterans and eligible persons, including coordination with the Veterans Administration in its carrying out of the Veterans Outreach Services Program under subchapter IV of chapter 3 of 38 U.S.C., and including the conduct of job fairs, job marts and other special programs to match veterans and eligible persons with appropriate job and job-training opportunities;

(4) Assist in securing and maintaining current information on available employment and training opportunities, using, when feasible, electronic data processing and telecommunications systems, and in matching veteran and eligible persons applicants' qualifications with available jobs, training and apprenticeship opportunities;

(5) Promote the interest of employers and labor unions in employing and in conducting on-the-job training and apprenticeship programs for veterans and eligible persons;

(6) Maintain regular contact with employers, labor unions, training program sponsors and veterans organizations to keep them advised of veterans and eligible persons who are available for employment and training;

(7) Keep veterans and eligible persons advised of opportunities for employment and training; and

(8) Coordinate, in conjunction with the RVER as appropriate, ETA activities relating to veterans services within the State with the activities of other agencies and organizations such as the Veterans Administration, the Department of Defense, the U.S. Civil Service Commission, the Department of Health, Education, and Welfare, State agencies such as Vocational Rehabilitation agencies, Governors Committees on Employment of the Handicapped, and unions, veterans organizations, employer associations and other community groups.

(9) Monitor and evaluate State agency performance under this subpart using local office and State agency reports including:

(i) Monthly, quarterly and annual reports of actual activity levels generated by required data systems;

(ii) Reports generated by the State agency Self-Appraisal System; and

(iii) Internal reports prepared by State agency staffs such as field supervisory, technical assistance and research staffs.

(10) Compare actual services to veterans and eligible persons against the standards for State agency performance set forth at § 653.221-26.

(11) Conduct periodic onsite reviews of local offices to assess their performance under this subpart. Such reviews shall include detailed, comprehensive analyses of all local office activities related to serving veterans and eligible persons, and spot-checks of particular local offices to validate information the SVER has obtained through the State agency Self-Appraisal System, regular data systems, field supervisors, technical staff or otherwise. The SVER shall review the performance of large local offices at least once each fiscal year on a formal, comprehensive, in-depth basis, and shall periodically review smaller local offices which evidence problems in providing services to veterans and eligible persons pursuant to this subpart until the problems are resolved.

STANDARDS OF PERFORMANCE GOVERNING STATE AGENCY SERVICES TO VETERANS AND ELIGIBLE PERSONS

§ 653.220 Standards of performance.

Sections 653.221-225 set forth the standards of performance governing services to veterans and eligible persons which must be met by the State employment service agencies.

§ 653.221 Standards of performance governing State agency services.

(a) Each State agency shall assure that all of its local offices, using LVERs and other staff, offer the following services to all veterans and eligible persons:

(1) *Registration*. Local offices shall encourage all veterans and eligible persons to file complete applications for appropriate job or training opportunities by explaining the services they may expect to receive on the filing of a full application. Local offices, however, may take partial applications for veterans and eligible persons if they are job attached, or if they are on strike or layoff and expecting to return to work unless such applicants request the opportunity to file full applications. Local offices may also take partial applications on veteran and eligible person applicants who say they do not wish to file full applications after the benefits of filing a full application have been explained to them.

(2) *Interviewing*. As appropriate, local offices shall interview veterans and eligible persons on a priority basis to review and analyze the information on their application cards, to assure that all of the applicants' qualifications for employment are adequately presented, to determine any need for employment counseling, to evaluate the occupationally significant facts about the applicants, and to select suitable job choices and job-finding techniques.

(3) *Counseling*. As appropriate, qualified local office staff shall discuss with veteran and eligible person applicants on a priority basis their present and potential qualifications for work, alternative vocational choices, and occupational requirements to assist them in formulating a plan to achieve their occupational and/or training goals. As appropriate, the counselors shall also provide such applicants with assistance in solving problems relating to the obtaining or holding of jobs.

(4) *Testing*. As appropriate, qualified local office staff shall administer objective aptitude and proficiency tests to veteran and eligible person applicants on a priority basis.

(5) *Referral to supportive services*. As appropriate, local offices shall refer veteran and eligible person applicants on a priority basis to supportive services available in the community such as medical, legal aid, child care and transportation assistance, which are likely to assist them to obtain employment and/or training.

(6) *Job development*. As appropriate, local offices shall attempt to develop job openings for veteran and eligible person applicants on a priority basis through employer contacts and otherwise whenever suitable job openings are not available in local office files. Such efforts shall include attempts to foster the elimination of hiring requirements not related to job performance.

(7) *Job and training referral*. (i) Whenever there is more than one applicant qualified for a job opening, including a job opening listed under the mandatory listing requirement of 38 U.S.C. 2012, or for a training opportunity, local offices, except as provided in paragraph (a)(7)(ii) of this section, shall observe the following order of priority in making referrals to the job openings or training opportunity:

(1) Qualified special disabled veterans;

(2) Qualified veterans of the Vietnam era;

(3) Qualified disabled veterans;

(4) All other qualified veterans and eligible persons;

(5) Qualified nonveterans.

(ii) Whenever a State agency or a local office is a subgrantee or contractor under the Comprehensive Employment and Training Act (CETA) or Title IV of the Social Security Act (Work Incentive (WIN) Program), the local office shall refer veterans to job and training opportunities under those programs in accordance with the CETA regulations at 29 CFR Parts 94-99 or the WIN regulations at 29 CFR Part 56.

(b) State agencies shall:

(1) Establish outreach programs designed to make veterans and eligible persons aware of the ES services available to them. Such programs shall include contact with veterans organizations, Veterans Administration facilities, military bases, military hospitals and other appropriate organizations. The State agency public information program shall develop and disseminate labor market information to assist veterans and eligible persons in job search activities, using public service announcements in the media as appropriate.

(2) Provide special designation, filing and retrieval procedures in each local office to readily identify veteran and eligible person applications and to monitor the provision of services to veteran and eligible person applicants on a priority basis. Separate special designation shall also be given to applications of disabled veterans.

(c) Local offices shall review veteran and eligible person applications each 30 calendar days and, if no reportable service has been recorded during the previous 30 calendar days, shall, if possible, determine each applicant's current status and desire for further ES assistance by telephone, visit, or mail. If further assistance is desired by the applicant, the local office shall initiate reportable services as appropriate. The term "reportable services", as used in this paragraph, shall mean counseling, job development, referral to a job, referral to training, referral to supportive services, testing and placement. A call-in shall also be considered as a reportable service, but only if the call-in is made to initiate another reportable service and only if contact is successfully made with the applicant by telephone or if the applicant responds to a mailed call-in card. All reportable services given shall be noted on the applicant's application card.

(d) Local offices shall assure that the applications of veterans and eligible persons are not automatically inactivated in accordance with normal procedures without the following special review:

(1) Identification of the applications of veterans and eligible persons scheduled for inactivation;

(2) A file search for their records; and evidence that warrants inactivation such as placement in a job or training opportunity, an explicit request from an applicant to inactivate an application, notice that applicant has moved out of the local office jurisdiction, etc. If inactivation is scheduled but not warranted, appropriate reinstatement actions should be taken.

(e) Local offices shall conduct job development activities including efforts to encourage the elimination of hiring requirements not related to job performance on behalf of veterans and eligible persons.

(f) Whenever feasible, local offices shall refer qualified veterans and eligible applicants within two working days after they file their applications to job opportunities developed under the mandatory listing requirement of the Department's regulations at 41 CFR Part 60–250, under the Comprehensive Employment and Training Act (CETA), or contained in Job Bank listings. If necessary, local office hours and staff working schedules shall be adjusted so that this requirement can be met.

(g) Local offices shall assure that the applications of veterans and eligible persons are never inactivated without a special review consisting of:

(1) The identification of the applications and records of veterans and eligible persons scheduled for inactivation; and

(2) The examination of each application for evidence that warrants its inactivation such as evidence that the applicant has been placed in a job or training opportunity, or of an explicit request from an applicant to inactivate an application, or that applicant has moved out of the local office's jurisdiction, etc.

§ 653.222 Performance standard on facilities for VES staff.

Each State agency shall provide adequate and appropriate facilities to the SVER, AVERs and VES support staff attached to the State agency.

§ 653.223 Performance standards on reporting.

(a) State agencies shall provide RVERs, SVERs, and AVERs with access to regular and special internal State agency reports which relate in whole or in part with services to veterans and/or eligible persons.

(b) No special reporting requirements are established by this subpart. Existing reporting systems include information on services to veterans and eligible persons and shall be used by ETA and the State agencies to administer the provisions of this subpart. ETA, however, may require special reports from State agencies from time to time.

§ 653.224 Performance standards governing the assignment and role of Local Veterans' Employment Representatives (LVERs).

(a) At least one member of each State agency staff, preferably an eligible veteran, shall be assigned by the State Director as a full-time Local Veterans' Employment Representative (LVER) to every local office which:

(1) Has had 1,000 new and renewal applications from veterans and eligible persons during the last Federal fiscal year; or

(2) Has a total of 6,000 veterans and eligible persons in the local office administrative area population.

(b) The State Director may:

(1) Assign additional full-time LVERs to local offices described in paragraph (a) of this section based on the State Director's determination of need; and

(2) Assign less than full-time LVERs to local offices described in paragraph (a) of this section if a lack of need for a full-time LVER is documented to the satisfaction of the Director, VES, as evidenced by the written approval of the Director, VES.

(c) The State Director shall assign LVERs on a part-time basis to local offices other than those described in paragraph (a) of this section. State Directors shall assure that periodic evaluations are made to determine the adequacy of services provided to veterans and eligible persons, and if necessary, they shall reallocate the time devoted to serving veterans and eligible persons by, for example, assigning additional full-time LVERs.

(d) Each LVER shall discharge, at the local office level, the duties prescribed for the LVER in paragraph (d) of § 653.214 The LVER may also be delegated line supervision over veterans units, assistant LVERs and veteran aides and may be assigned direct duties with respect to services for veterans and eligible persons by the local office manager.

(e) Each LVER shall be administratively responsible to the local office manager and shall provide functional supervision over all local office services to veterans and eligible persons. The term "functional supervision" as used in this paragraph shall mean evaluating local office personnel in their performance of services to veterans and eligible persons and assisting them to carry out these services more effectively.

(1) Functional supervision entails providing technical assistance, making suggestions for the improvement of services, helping to plan programs, initiating projects, checking for compliance with regulations, helping to correct errors by working with local office staff, analyzing work as it affects veterans and eligible persons, training new local office employees, providing refresher courses for other staff, and assisting all local office personnel to improve services to veterans and eligible persons. It also involves the bringing of matters which the LVER believes require corrective action to the attention of the local office manager and other officials who have line authority to set or change policy and procedure and to supervise staff.

(2) Functional supervision does not entail the right to hire, fire, or discipline any local office employee. Nor does it authorize an LVER to make regulations, change procedures or establish policies for the local office without specific authority from the local office manager.

§ 653.225 Standards of performance governing State agency cooperation and coordination with other agencies and organizations interested in the employment development of veterans and eligible persons.

(a) Each State agency shall establish cooperative working relationships with the Veterans Administration (VA) office serving the State to maximize the use of VA training programs for veterans and eligible persons, particularly on-the-job and other skill training. Such working relationships should provide for the exchange of information on available training opportunities and on veterans and eligible persons available to be trained, the placing of job orders with the ES by employers who provide VA-approved on-the-job training, the referral of veterans and eligible persons to such job openings, and joint ES–VA programs to aid VA field staff in providing assistance to employers with VA programs. Each State agency should develop a written agreement with its VA counterpart covering areas of mutual concern and delineating each agency's areas of responsibility.

(b) Each State agency shall develop cooperative arrangements with public agencies and other organizations who are sponsors of programs under the Comprehensive Employment and Training Act of 1973 (CETA). State agencies shall make their staffs aware of the fact that, under section 205(c)(5) of the Comprehensive Employment and Training Act, sponsors of public service employment programs under Title II of that Act are required to make special efforts to acquaint veterans with the public service jobs available under Title II of CETA and to coordinate their efforts on behalf of veterans with ES activities under this subpart.

§ 653.226 Standards of performance governing complaints of veterans and eligible persons.

(a) Any veteran or eligible person may file a complaint with the LVER. The

LVER shall handle the complaint in accordance with the provisions of Subpart E of Part 658 of this chapter except that, if the complaint relates to the responsibilities of an employer under 38 U.S.C. 2012, the LVER shall follow the Department's complaint procedures set forth at 41 CFR Part 60–250.

(b) Each local office shall have information on the complaint system available to veterans and eligible persons at all times, and shall display a poster which advises applicants about the system.

FEDERAL MONITORING OF STATE AGENCY COMPLIANCE

§ 653.230 Veterans preference indicators of compliance.

(a) To help in determining whether the standards of performance set forth in §§ 653.221–226 are being met, the ETA shall use the floor levels and the veterans preference indicators of compliance set forth in this section to compare the level of services provided to veterans and eligible persons with the level of services provided to nonveterans.

(b) The term "applicants" as used in this section shall mean individuals who filed or renewed job applications during the fiscal year. To improve statistical comparability, the term "nonveteran" as used in this section shall not include women and persons 19 years of age or younger. The term "veteran" as used in this section, shall include eligible persons. The term "disabled veteran", as used in this section, shall include "special disabled veteran".

(c) To prevent State agencies, which are actually performing at low levels of accomplishment, from mathematically appearing, according to the veterans preference indicators of compliance, to be doing well, the ETA shall establish a floor (minimum) level of expected accomplishment for each State for each reportable service for each Federal fiscal year. Only after a State agency reaches its expected floor level of accomplishment shall the veterans preference indicators of compliance be applied. Each year ETA shall consider each State agency's past year's accomplishments as a major factor in establishing the floor level of accomplishment for the next Federal fiscal year. Computation of the floor levels shall also be based on external and other appropriate factors. The floor levels of accomplishment shall be stated as follows:

(1) $\dfrac{\text{Veterans Counseled}}{\text{Veteran Applicants}} \times 100 \text{ percent} =$

(2) $\dfrac{\text{Veterans Enrolled in Training}}{\text{Veterans Applicable}} \times 100 \text{ percent} =$

(3) $\dfrac{\text{Veteran Job Development Contacts}}{\text{Veterans Applicable}} \times 100 \text{ percent} =$

(4) $\dfrac{\text{Veteran Applicants Placed}}{\text{Veterans Applicants}} \times 100 \text{ percent} =$

(5) $\dfrac{\text{Veteran Applicants Inactivated with Some Service}}{\text{Veteran Applicants}} \times 100 \text{ percent} =$

ETA shall periodically publish numerical values to fill out these floor level equations in the FEDERAL REGISTER as amendments to this section.

(d) The ETA shall compare the level of State agency services for veterans versus that for nonveterans by examining rates of service rather than the numbers of persons served to compensate for the differing sizes of comparison groups and to avoid the difficulties associated with establishing absolute numbers under varying conditions, time periods and locations. In addition, the two groups, veterans and nonveterans, shall be compared after adjustments for demographic and other appropriate characteristics to make them as comparable as possible within the limitations of available data systems.

(e) ETA shall establish numerical values for the veterans preference indicators of compliance for each Federal fiscal year for:

(1) Veterans versus nonveterans;

(2) Veterans of the Vietnam era versus nonveterans; and

(3) Disabled veterans versus nonveterans.

(f) Veterans preference indicators of compliance for service to all veterans shall be stated as follows:

(1) The ratio of veteran applicants counseled to the total number of veteran applicants shall exceed the ratio of nonveteran applicants counseled to the total number of nonveteran applicants by at least ____________ percent.

$$\frac{\text{Veteran counseled}}{\text{Veteran applicants}} \div \frac{\text{Nonveterans counseled}}{\text{Nonveteran applicants}} - 1.00 = \text{\_\_\_\_}\ \%$$

(2) The ratio of veteran applicants referred to training to the total number of veteran applicants shall exceed the ratio of nonveteran applicants referred to training to the total number of nonveteran applicants by at least __ %. percent.

$$\frac{\text{Veterans enrolled in training}}{\text{Veteran applicants}} \div \frac{\text{Nonveterans enrolled in training}}{\text{Nonveteran applicants}} - 1.00 = \text{\_\_\_\_}\ \%$$

(3) The ratio of job development contacts made for veterans to the total number of veteran applicants shall exceed the ratio of job development contacts made for nonveterans to the total number of nonveteran applicants by at least __ %.

$$\frac{\text{Job development contacts for veterans}}{\text{Veteran applicants}} \div \frac{\text{Job development contacts for nonveterans}}{\text{Nonveteran applicants}} - 1.00 = \text{\_\_\_\_}\ \%$$

(4) The ratio of veteran applicants placed in jobs to the total number of veteran applicants shall exceed the ratio of nonveteran applicants placed in jobs to the total number of nonveteran applicants by at least __ %.

$$\frac{\text{Veterans placed}}{\text{Veteran applicants}} \div \frac{\text{Nonveterans placed}}{\text{Nonveteran applicants}} - 1.00 = \text{\_\_\_\_}\ \%$$

(5) The ratio of veteran applicants inactivated with some service to the total number of veteran applicants shall be more than the ratio of nonveteran applicants inactivated with some service to the total number of nonveteran applicants by at least __ percent.

$$\frac{\text{Veterans inactivated with some service}}{\text{Veteran applicants}} \div \frac{\text{Nonveterans inactivated with some service}}{\text{Nonveterans applicants}} - 1.00 = \text{\_\_\_\_}$$

(g) Veterans preference indicators of compliance for service to veterans of the Vietnam era are as follows:

(1) The ratio of Vietnam-era veteran applicants counseled to the total number of Vietnam-era applicants shall exceed the ratio of nonveteran applicants counseled to the total number of nonveteran applicants by at least __ percent.

$$\frac{\text{Vietnam-era veterans counseled}}{\text{Vietnam-era veteran applicants}} \div \frac{\text{Nonveterans counseled}}{\text{Nonveteran applicants}} - 1.00$$

(2) The ratio of Vietnam-era veteran applicants enrolled in training to the total number of Vietnam-era veteran applicants shall exceed the ratio of nonveteran applicants enrolled in training to the total number of nonveteran applicants by at least __ percent.

$$\frac{\text{Vietnam-era veterans enrolled in training}}{\text{Vietnam-era veteran applicants}} \div \frac{\text{Nonveterans enrolled in training}}{\text{Nonveteran applicants}} - 1.00 = \text{\_\_\_\_}\ \%$$

(3) The ratio of job development contacts made for Vietnam-era veterans to the total number of Vietnam-era veteran applicants shall exceed the ratio of job development contacts made for nonveterans to the total number of nonveteran applicants by at least __ percent.

$$\frac{\text{Job development contacts for Vietnam-era veterans}}{\text{Vietnam-era veteran applicants}} \div \frac{\text{Job development contacts for nonveterans}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(4) The ratio of Vietnam-era veteran applicants placed in jobs to the total number of Vietnam-era veteran applicants shall exceed the ratio of nonveteran applicants placed in jobs to the total number of nonveteran applicants by at least -- percent.

$$\frac{\text{Vietnam-era veterans placed}}{\text{Vietnam-era veteran applicants}} \div \frac{\text{Nonveterans placed}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(5) The ratio of Vietnam-era veteran applicants inactivated with some service to the total number of Vietnam-era veteran applicants shall be more than the ratio of non-veteran applicants inactivated with some service to the total number of nonveteran applicants by at least -- %.

$$\frac{\text{Vietnam-era veterans inactivated with some service}}{\text{Vietnam-era veteran applicants}} \div \frac{\text{Nonveterans inactivated with some service}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(h) Veterans preference indicators of compliance for service to disabled veterans are as follows:

(1) The ratio of disabled veteran applicants counseled to the total number of disabled veteran applicants shall exceed the ratio of nonveteran applicants counseled to the total number of nonveteran applicants by at least -- %.

$$\frac{\text{Disabled veterans counseled}}{\text{Disabled veteran applicants}} \div \frac{\text{Nonveterans counseled}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(2) The ratio of disabled veteran applicants enrolled in training to the total number of disabled veteran applicants shall exceed the ratio of nonveteran applicants enrolled in training to the total number of nonveteran applicants by at least--percent.

$$\frac{\text{Disabled veterans enrolled in training}}{\text{Disabled veteran applicants}} \div \frac{\text{Nonveterans enrolled in training}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(3) The ratio of job development made for disabled veterans to the total number of disabled veteran applicants shall exceed the ratio of job development contacts made for nonveterans to the total number of nonveteran applicants by at least -- percent.

$$\frac{\text{Job development contacts for disabled veterans}}{\text{Disabled veteran applicants}} \div \frac{\text{Job development nonveterans}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(4) The ratio of disabled veteran applicants placed in jobs to the total number of disabled veteran applicants shall exceed the ratio of nonveteran applicants placed in jobs to the total number of nonveteran applicants by at least -- %.

$$\frac{\text{Disabled veterans placed}}{\text{Disabled veteran applicants}} \div \frac{\text{Nonveterans placed}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(5) The ratio of disabled veteran applicants inactivated with some service to the total number of disabled veteran applicants shall exceed the ratio of nonveterans inactivated with some service to the total number of nonveteran applicants by at least -- percent.

$$\frac{\text{Disabled veterans inactivated with some service}}{\text{Disabled veteran applicants}} \div \frac{\text{Nonveterans inactivated with some service}}{\text{Nonveteran applicants}} - 1.00 = \text{....}\%$$

(i) The veterans preference indicator of compliance for State agency action under the mandatory job listing requirements of 38 U.S.C. 2012 shall be: The ratio of the total number of veterans of the Vietnam era and special disabled veterans placed in mandatory listing job openings to total number of individuals placed in mandatory listing job openings shall exceed 20 percent.

(j) Following analysis of the past year's accomplishments, the numerical value for each of the veterans preference compliance indicators will be published in the FEDERAL REGISTER as amendments to paragraphs (f), (g) and (h) of this section.

(k) State agency performance under this subpart shall be reviewed on a quarterly basis by the ETA regional offices during the conduct of regular Operational Planning and Review System (OPRS) reviews. In addition, State agency performance under this subpart shall be formally reviewed by the ETA national office on an annual basis using the floor levels of accomplishment and the veterans preference indicators of compliance. The full results of these reviews shall be incorporated into the Secretary's annual report to the Congress. If a State agency fails to meet three of the five floor levels of accomplishment set forth at paragraph (c) of this section, including the floor level for placement, or if it fails to meet more than one-half of the total number of veterans preference indicators of compliance, with each placement indicator having double weight, ETA shall consider this as evidence that the State agency is not complying with the performance standards at § 653.221-226. Such State agencies shall be required to provide documentary evidence to the ETA that their failure is based on good cause. If good cause is not shown, the ETA, pursuant to Subpart H of Part 658 of this chapter, shall formally designate the State agency as out of compliance, shall require it to submit a corrective action plan for the following Federal fiscal year, and may take other action against the State agency pursuant to Subpart H of Part 658 of this chapter.

(l) Even though a State agency veterans' services statistics, including the floor levels of accomplishment and the veterans preference indicators of compliance, indicate adequate services to veterans, the ETA may take corrective action against a State agency pursuant to Subpart H of Part 658 of this chapter if other information comes to the attention of the ETA which indicates that a State agency is not complying with the requirements of this subpart.

§ 653.231 Secretary's annual report to Congress.

(a) The Secretary shall report, after the end of each Federal fiscal year, on the success of the Department and the State agencies in carrying out the provisions of this subpart. The report shall include, by State:

(1) The number of recently discharged or released eligible veterans, disabled veterans, other eligible veterans and eligible persons who requested assistance through the State agency; and

(2) Of the categories set forth in paragraph (a)(1) of this section, the number placed in employment, placed in job-training opportunities, or otherwise assisted.

(b) The report shall include any determinations that:

(1) A State agency demonstrated a lack of need for assigning a full-time LVER in accordance with § 653.224 (b)(2); and

(2) Funds made available under the prior year's appropriations Act were not needed for carrying out the purposes of this subpart.

(c) The report shall include a designation of State agencies which ETA formally designated as out of compliance pursuant to § 653.230(k) with the standards of performance set forth in this subpart along with those agencies' plans for corrective action during the succeeding Federal fiscal year.

Signed at Washington, D.C., this 27th day of October 1976.

WILLIAM H. KOLBERG,
Assistant Secretary for Employment and Training.

[FR Doc.76-31944 Filed [illegible]-76;8:45 am]

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Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

DENNIS K. RHOADES, DIRECTOR
NATIONAL ECONOMIC COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

VETERANS EMPLOYMENT LEGISLATION, S. 999, AND
ADMINISTRATION-REQUESTED LEGISLATION, S. 918, TO
MODIFY VETERANS EDUCATION PROGRAMS

April 30, 1987

STATEMENT OF
DENNIS K. RHOADES
DIRECTOR
NATIONAL ECONOMIC COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
Washington, D.C.

April 30, 1987

Mr. Chairman, The American Legion is pleased to have the opportunity to appear before this Committee today to share our views on veterans job programs. Employment and training is a vital, but too often neglected component of our entire veterans services system. We are grateful to you not only for developing S.999, which we will discuss in a moment, but also for taking the time to conduct a broad assessment of current programs. We are convinced that these programs, the components of which were often developed in response to a particular employment problem among Vietnam-era veterans, is in need of reassessment and refinement, with a view toward setting in place a permanent, flexible veterans employment and training structure.

In that regard, those provisions of S.999 which would amend chapter 41 of title 38 represent a good first step in the refinement process, as well as responding to an immediate need to bring stability to the local veterans employment representative (LVER) program. As the Committee is aware, the Administration has attempted to propose substantial reductions in the numbers of LVERs in its proposed budgets for the last two fiscal years. Its device for justifying these reductions was the elimination, by a 1985 regulatory change, of a population criterion to determine the number of LVER positions required by local public employment service offices. In the proposed 1988 budget, the Administration went even further: it proposed to reduce the number of

LVERs below the level required by its own revised regulations on the basis that LVERs were functional supervisors, and that the degree of supervision required was less than the number of positions funded. While functional supervision is a key element in the duties of an LVER, it is by no means the only one. Chapter 41 lists no less than eleven major tasks for LVERs, in addition to supervision.

Another major Administration criticism of this measure is a claim that the veterans population in an employment office service area would be virtually impossible to determine. As you are aware, Mr. Chairman, for nearly a decade prior to 1985, a population criterion was used to determine whether or not a local office was required to have a fulltime LVER. The American Legion thus finds it difficult to believe that census projections or other data sources used previously have suddenly vanished. Working with the Veterans Administration and the Bureau of the Census, we are confident of the Department of Labor's ability to retrieve these suddenly lost data.

We are also pleased to note that S.999 includes a provision for an additional LVER in a local office for every 1500 applicants above the 1000 which mandate fulltime status. According to the Congressional Budget Office, there are approximately 160 such offices nationwide. Anyone who has ever visited or worked in a local employment office in a large city or high unemployment area recognizes that the workload of a conscientious LVER is overwhelming, and that providing each veteran applicant who visits and/or registers in that office with high quality service is nearly impossible. Moreover, it is apparent when one reviews the level of services in a large employment office, that veterans are, as a general rule, underserved. We believe that the additional LVER will greatly alleviate that problem .

Mr. Chairman, we applaud the provisions of S.999 which would make LVERs and their counterparts in the Disabled Veterans Outreach Program (DVOP) functionally responsible to the Department of Labor's State Directors for Veterans Employment. The relationship between State and Assistant State Directors is only tenuously outlined in current statute, and was long overdue for clarification. It has been my personal observation that the veterans employment program within the public employment service is most effective in those states where such a relationship exists. I have spoken with some officials associated with the employment service who are at first uneasy with this proposed requirement, until I have explained that "functional" supervision is quite distinct from "line" supervision, and that these provisions will in no way impose a dual management structure on the LVER or DVOP program. In the Legion's view, the assignment of functional responsibility should have two consequences: First, it will speed the development of a more nationally uniform position description, thus curtailing abuse of these positions by certain State agencies. Second, the requirement will become a part of the grant negotiation process, and the duties prescribed for LVERs and DVOPs under chapter 41 will become a clearer part of the grant.

Taken together, these changes in the LVER program should lend new strength to the public employment service's efforts to find jobs for our nation's veterans, provided that there is such an entity as an employment service. The American Legion continues to be concerned, however, about the Administration's proposal to disband the present system of employment service offices in favor of a decentralized state or locally operated labor exchange function. I do not believe that the Legion needs to remind this distinguished committee of the consequences of this proposal, which is often called "devolution." Much of what constitutes chapter 41 is built upon the underlying assumption that there will be a system of discrete public employment service agencies, operating in a partnership under Federal guidelines. It is our belief that any attempt to alter that system along the lines of the Administration's proposal will have a profound effect upon chapters 41 and 42, and will thus require careful scrutiny by the Veterans Affairs Committee as a part of the legislative process. The American Legion hopes that the Committee will closely observe the progress of any such devolution proposal, and take such action as necessary to protect the interest of veterans.

It is also gratifying to note that S.999 proposes to require by statute a National Veterans Employment and Training Institute. I have had the opportunity last week to visit the National Veterans Training Institute in Denver, and believe it to be one of the best initiatives in the veterans employment and training area during the last decade. The provision of professional training to those responsible for assisting unemployed and underemployed veterans is certainly greatly needed, as demonstrated by the experience of the Veterans Job Training Act with the non job ready veteran. Our only concern is funding for the Institute. Currently, the training is being paid for from "excess" LVER and DVOP funds. The variation in this "excess", however, concerns the Legion, as well as what may become a tendency to hold back funding, preventing one or both programs from being fully staffed as the Congress intended. We suggest, therefore, that section 2006 of chapter 41 be amended to include a provision which would require a separate line item for the Institute in the budget.

Mr. Chairman, we would now like to turn to the Veterans Job Training Act (VJTA) provisions of S.999. VJTA has now been with us since early 1984, and has placed into training well over 50,000 Vietnam-era and Korean veterans. We are grateful, in addition, for your support, and that of your colleagues on the Committee, for a two year reauthorization of the program, as well as for a supplemental appropriation to carry VJTA through the end of FY 87. We hope that the Committee will move swiftly on these measures to assure their passage this spring.

In its original form, VJTA was developed to respond to an historically high incidence of unemployment among Vietnam-era veterans. Yet, The American Legion believes that it is important to recall the second reason for VJTA's creation: the formulation of the Job Training Partnership Act (JTPA) in 1982. Unlike its predecessors, JTPA provided no preference, special consideration, or targetting of veterans. In order to meet the employment training needs of veterans, VJTA therefore served--and still serves--as an alternative source of job skills training. The Centaur studies of VJTA, however, make it clear that while the program may well serve those veterans who are job ready, it has few resources to provide the ancillary supportive services necessary to assure that the non job ready are able to benefit from their on-the-job training experience. The high attrition rate in VJTA does not warrant the conclusion that the program is not necessary. Rather, any program with such dropout rates highlights both the fact that there is a substantial core of veterans for whom transition back into the labor force is difficult, and that there are presently inadequate resources to assist with that transition.

S.999 attempts to address the supportive service issue principally through the addition of pretraining and reentry counseling requirements, as well as delayed training reimbursements to employers. The counseling requirements should certainly be useful in increasing program retention, as long as quality counseling is available and put to work. In our view, however, neither the VA nor the formal counseling provided on increasingly rarer occasions by the public employment service will be sufficiently available to all VJTA clients. We believe the Department of Labor and the Veterans Administration need to develop a comprehensive plan to implement these new provisions of law. First, we believe that an assessment system must be developed for use by LVERs and DVOPs in determining a prima facie need for counseling. This assessment would refer to professionally trained counselors those veterans most clearly in need of services and who are likely to benefit the most from it. Other veterans should be provided with more informal, but no less effective counseling in job adjustment. To this end, we believe the National Veterans Training Institute could develop training in such counseling, using train-the-trainer techniques in order to provide such training quickly. In any case, the counseling requirement should not be left to chance, but must be implemented through a rational and thorough planning. The agencies should also examine carefully the need for post-placement counseling, where voluntary counseling intervention could be useful in salvaging the relationship between the veterans and his or her employer/trainer.

Mr. Chairman, The American Legion does perceive some problems with the proposed adjustment of the employer reimbursement formula. On-the-job training under the Job Training Partnership Act pays the employer in the same way that present law requires under VJTA: 50 percent of the trainee's gross starting wages. We understand the reasoning behind the bill's proposal to alter the formula such that the employer receives 30 percent in the beginning and the remaining 20 percent as a lump sum at the conclusion of training. Our concern is that, even with the lump sum payment at the end of the training period, this change will render VJTA uncompetitive with its larger JTPA rival. We are, however, willing to test this change, as long as the Department of Labor and the VA carefully monitor its results, and the effect on employer participation. We believe that Congress should be ready to restore the original funding formula should this change result in a significant dampening effect upon employer acceptance.

We might add, also, that the Department of Labor should be examining the entire employer recruitment program. As it is currently operated, employer recruitment is conducted rather randomly, with insufficient regard to the job needs of veterans registered for work in the local office. We would suggest that the Department might institute a short term pilot project in some ES offices which would begin with an assessment of the job desires and capabilities of veterans actually registered in the file, followed by the development of a recruitment effort based upon the assessment results.

Mr. Chairman, S.999 is an ambitious piece of legislation which The American Legion fully supports. The measure attempts to resolve some urgent problems in the nation's veterans employment and training system. None of us in this room today, however, are so sanguine as to believe that the passage of this legislation will cure all of the ills of the present system. Other changes to chapters 41 and 42 of title 38 are going to be necessary, in our view, during the next year or two. While addressing in detail the role of veterans in this country's public labor exchange agencies, for example, chapter 41 only tangentially addresses the role of veterans in the nation's employment training system. The result has been a piecemeal effort--VJTA, HIRE, "special consideration" for veterans under CETA, just to name a few. We believe it is time to take a serious look at employment training in the context of chapter 41. Another issue of concern is the sunset provisions of chapter 42, which would statutorily abolish Vietnam-era veterans as a statutory group, references to which appear in abundance throughout chapters 41 and 42. There are other issues as well, including the fragile position of the Regional Directors for Veterans Employment and Training--the top field managers in the Veterans Employment and Training Service.

The American Legion thus views S.999, as we indicated in the beginning of our statement, as one of several steps in developing a permanent and flexible employment and training system for veterans. We look forward to working with you, your colleagues, and Committee staff in addressing these other vital issues in the coming months.

Mr. Chairman, we will now turn our attention to the other matter being considered for today's hearing. This is the legislation, S. 918, introduced at the request of the Administration and intended to make several modifications in veterans education programs.

Section 101 of this bill would amend section 1411 (c)(1) to allow an election not to participate in the basic educational assistance entitlement under Chapter 30 to be made within 14 days of entrance onto active duty, rather than at the time the individual offers a period of time for the enlistee to consider this education program and its potential benefits prior to the time that a final decision is required.

Section 102 would amend Chapter 31 so as to delete the provision for advance payment of subsistence allowance for the vocational rehabilitation program. Advance payment of education benefits was originally granted to those under Chapter 34 in the mid 1970s. It was extended to Chapter 31 in 1980. Although the Veterans Administration pays the training costs in a program of vocational rehabilitation, there are additional expenses involved with beginning such a program. These involve travel, lost wages and other issues which may create a need for the advance payment. Therefore, The American Legion would not support this proposal.

Section 103 of the bill would delete the advance payment of a portion of the VA workstudy allowance. As we understand it the reasoning for this legislation is that overpayments are a major problem in this program. The overpayments apparently stem from large numbers of veterans dropping out of school. Administrative offsets are not feasible and the payments are relatively small. It would appear to us that there exists a lack of administrative control to prevent such overpayments. The Administration's solution is to discontinue the benefit rather than to correct the situation. We do not support this proposal.

Section 104 of the measure would amend the definition of the term "standard classroom session" pertaining to laboratory instruction to reflect current institutional practices of having lab instruction courses of two 50 minute periods rather than a standard two hour lab. This is a technical amendment to which we would not offer objection.

Section 105 would delete the current requirement of annual compliance surveys of institutions offering approved courses in which 300 or more veterans are enrolled or which offer NCD courses. Surveys would be conducted "whenever appropriate and in the best interests of the Government". The reason behind this proposal is that it would reportedly permit a more effective use of VA personnel and still maintain active and effective enforcement of the law and regulations.

It would appear to us that these surveys, completed on a regular basis, are an essential means of ensuring the compliance of schools with the law and regulations. In addition, regularly conducted surveys should be a significant factor in reducing the overpayment problem. Therefore, we would not support this provision.

It would appear to us that these surveys, completed on a regular basis, are an essential means of ensuring the compliance of schools with the law and regulations. In addition, regularly conducted surveys should be a significant factor in reducing the overpayment problem. Therefore, we would not support this provision.

Section 106 would amend section 3013 of title 38, to require that awards under Chapter 32 (VEAP) correspond to the extent feasible with the effective dates relating to awards under the other education programs included in this title. This is a technical amendment to which we would have no objection.

Section 201 of the bill would repeal the authority that permits the Veterans Administration to make education loans where there is unused entitlement remaining at the expiration of a veteran's delimiting period, provided he or she was pursuing a program of education on a full-time basis at the time. This has been attempted several times in the past. Although, an earlier cost-savings measure, the Omnibus Budget Reconciliation Act of 1981, limited the number of individuals eligible for VA education loans, those who retain eligibility and who depend on these loans could be forced to discontinue their program of education or training. Thus, The American Legion opposes this initiative as we have previously.

This section would also amend sections 1682A and 1738 which authorize eligible veterans and eligible persons, respectively, to receive education loans in the form of accelerated payments of educational assistance allowances. Accelerated payment under these sections was made contingent upon establishment before November 24, 1982 of programs by States to pay the VA amounts which would match the accelerated payments authorized by VA. Since no States participated in this program, and the lifetime of the program has expired, we would not object to the repeal of these sections.

Mr. Chairman, that concludes our statement.

STATEMENT OF
RONALD W. DRACH
NATIONAL EMPLOYMENT DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
VETERANS AFFAIRS COMMITTEE
OF THE
UNITED STATES SENATE
April 30, 1987

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to appear before you today to discuss S. 999. We particularly want to thank you, Mr. Chairman, and Senators Matsunaga and DeConcini for the swiftness with which you have moved to improve veterans' employment and training programs so early in the 100th Congress. The Disabled American Veterans thanks you.

Mr. Chairman, many of the amendments to Chapter 41, Title 38, U.S. Code, proposed in S. 999 are long overdue. We are very pleased to note that Section 2 of the bill would require that DVOP personnel be functionally responsible to State and Assistant State Directors for Veterans' Employment and Training.

As you know, these individuals are state employees and are subject all too often to the whims of the local Office Manager. This results in their performing duties other than direct veterans' services. Making them responsible to the Veterans' Employment and Training Service should enhance their veterans' employment activities.

Under current law, the only real authority the Assistant Secretary has is to assure that the positions are filled and, on a periodic basis, monitor activities to determine compliance. We believe this current system is woefully inadequate to assure meaningful employment and training and, particularly, outreach activities on the part of DVOP personnel.

We view with interest the proposal that would mandate LVER positions on the basis of a formula using veterans registered during a 12 month period, or a service area veteran population formula.

We certainly agree that a numerical formula is necessary to assure an adequate number of LVERs. However, we urge you, Mr. Chairman, to consider the potential problems associated with a numerical formula based on veteran registrations.

The potential for manipulation of those data is of major concern to us. We believe that a veteran population formula should be substituted with one similar to that currently used for the assignment of DVOP personnel. In the event that the existing proposed formula is retained, please consider clarifying language which would include new and renewal applicants. Current language could be interpreted to restrict the registrants to only new applications.

The other danger in retaining the proposed formula, Mr. Chairman, is that it only captures those veterans who are actively seeking employment through the Job Service. We know that there are many veterans who have stopped using the Job Service for various reasons, including those who are out looking for employment on their own or who have dropped out of the workforce totally.

We also agree that similar to DVOP personnel, LVERs should be functionally responsible to State and Assistant State Directors for Veterans' Employment and Training. We support the requirement that LVERs discharge their duties exclusively to providing services to veterans.

The provision to have the LVERs assure counseling services are provided to eligible veterans under the Veterans Job Training Act is necessary. We strongly believe that an effective counseling effort would go far in reducing the high dropout rate in VJTA. The DAV supports statutorily established uniform performance standards for DVOP and LVER personnel. This again is needed to assure national uniformity in how DVOP and LVERs perform their duties.

We also support the requirement that an Assistant State Director participate in the annual performance rating of LVERs. This is certainly a natural extension of the functional responsibility concept.

Mr. Chairman, we also support the remaining changes relative to Chapter 41 contained in S. 999.

We would, however, emphasize our commitment to and support of the codification of a National Veterans' Employment and Training Service Institute established to provide ongoing training to LVERs, DVOPs, as well as State and Assistant State Directors for Veterans' Employment and Training "...and such other personnel involved in the provision of employment, job training, placement, or related services."

With the possible exception of the Administration, you will most likely find no one who opposes this idea. The Disabled American Veterans has long advocated the need for a national training program for these individuals and one has been established, administratively, in Denver, Colorado.

Assistant Secretary Shasteen is to be commended for his insight and action to fulfill that need. The codification of such a program is the next logical step to assure that existing personnel, as well as future personnel, have the opportunity to receive this much needed training.

Mr. Chairman, I have reviewed the curriculum used in Colorado. I have participated and spent several days at the institute in Denver and am very pleased to report that the University of Colorado has done an outstanding job of pulling together resources and knowledgeable persons to set up this program.

Mr. Chairman, scores of LVERs, DVOPs, office managers and others have gone through the training program in Denver. I offer for your consideration a few select testimonials from people who have participated.

> The week I attended proved to be one of the most intense weeks I have had in a long time. After getting back to reality, I found that I had gained something from every presentation, even the ones that I had considered not useful. (DVOP)
>
> I must say that it was by far the most rewarding and enlightening training I have experienced in my job as a DVOP...I have had many training sessions put on by the state but none can match this. My only hope is that these sessions can be ongoing and updated as we progress into the future. (DVOP)
>
> It was not only enlightening, but definitely the best that I have ever attended. (LVER)
>
> The National Veterans' Training Institute Program was intense both intellectually and emotionally. It was by far one of the best training programs I have attended. (LVER)
>
> What a splendid training experience. (DVOP)
>
> The NVTI course was absolutely the most meaningful, impressive, and enjoyable training I have ever received. (LVER)
>
> I recently completed one of the most enlightening experiences of my career -- a training course which, by the time it was over, became a very personal, emotional, and fulfilling happening.
>
> I feel, because I am a supervisor, that management and supervision should be encouraged to attend this meeting. It was most informative both from the fellowship of the trainees and the instruction given. (ES Supervisor II)

Mr. Chairman, we would now like to turn to some of the amendments being offered to the Veterans' Job Training Act.

We fully support your effort to authorize an additional appropriation of $60 million for each of Fiscal Years 1988 and 1989 for the Veterans' Job Training Act. We believe this, coupled with the other changes proposed in S. 999, significant strides will be made in alleviating the unemployment problems of Vietnam era and disabled veterans.

The provision to adjust the payment to employers, in our opinion, offers an incentive for employers to retain veterans throughout the entire training period. This, coupled with the Chapter 41 requirement to provide counseling, should enhance the veteran's ability to complete the program and transition into permanent competitive employment.

The Disabled American Veterans has long advocated the need for case managers to assist in the assimilation and provision of employment services. The idea of assigning a case manager to each veteran entering a VJTA training program is indeed commendable and visionary. The only suggestion we have would be, in addition to supportive help from the Vet Center counselors, to have supportive help from the Vocational Rehabilitation Specialist of the Vocational Rehabilitation Program.

We believe that the program of counseling services established in S. 999 that incorporates readjustment counseling services at Vet Centers, veterans' benefits counselors at VA Regional Offices and the counselors at the Career Development Centers, should also include Vocational Rehabilitation Specialists.

Mr. Chairman, there are many who may say S. 999 goes too far and tries to do too much. We think not. We are very pleased with this bill as is and only suggest your consideration to changing the LVER assignment formula.

Mr. Chairman, we would also urge you to consider the following recommended changes to Chapter 41.

Section 2003 currently mandates the assignment of a State Directors for Veterans' Employment and Training, an Assistant State Director and full time federal clerical support staff. It does not provide for the assignment of a Regional Director for Veterans' Employment and Training.

Section 2003 should be amended to mandate such a position. We also believe that there should be one in each of the ten federal regions as other components, including the Employment and Training Administration, have within the Department of Labor.

Several years ago, the Veterans' Employment and Training Service consolidated Regions IX and X and stationed the Regional Director in Seattle. This, of course, removed a Regional Director from the previously identified Region X which included California, the state of the Chairman. The Denver Region has been abolished and consolidated with the Kansas City Region and headquartered in Kansas City. The New York and Boston Regions have been consolidated with headquarters in Boston. It is our opinion that, in order to have an effective network, a line of progression must go from the national office to ten regional offices, then to the states.

Section 2002A requires an Assistant Secretary of Labor for Veterans' Employment be appointed by the President. This is commonly known as a Schedule C political appointment. The legislation is silent with respect to a Deputy Assistant Secretary but such a position has been encumbered and it, too, has been identified as a Schedule C political appointment.

Since the Assistant Secretary is subject to serve at the pleasure of the President and, as such, is not guaranteed employment, this obviously results in a probable change of personnel with every change in Administration. We have had two Assistant Secretaries during the two Reagan Administrations.

We believe that in order to provide continuity a Deputy Assistant Secretary should be mandated. The individual should be in a career Senior Executive Service position. We would urge an amendment to Section 2002A to reflect that need.

Section 2003(b)(1) requires the State and Assistant State Directors be an eligible veteran "who at the time of appointment has been a bona fide resident of the state for at least two years." In our opinion, this requirement is extremely restrictive to the upward mobility potential of existing Assistant State Directors.

These individuals, under current law, are restricted to applying for State Director jobs only in the state in which they reside. Many of these individuals have shown outstanding ability and attributes but are unable to be promoted to State Director positions in other states. We believe that an adequate waiver of the residency requirement would be to allow Assistant State Directors with two year's experience to be considered for State Director vacancies in states in which they do not reside.

Mr. Chairman, this concludes my prepared statement and again I would like to thank you for your early action in introducing S. 999. We urge the Committee to take rapid action to have S. 999 passed by the entire Senate and submitted to the House for its consideration.

I would be happy to answer any questions you may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

GORDON R. THORSON, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

VETERANS' EMPLOYMENT AND TRAINING
AND
VETERANS' EDUCATIONAL ASSISTANCE IMPROVEMENTS ACT OF 1987

WASHINGTON, D. C. APRIL 30, 1987

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The 2.7 million men and women of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary welcome this opportunity to express the viewpoint of our proud organization. It is my privilege to have been selected to represent the VFW's stance on these issues before this important Committee.

The invitation to this hearing clearly outlined the three areas of concern: First, S. 999, the proposed "Veterans' Employment and Training Amendments of 1987;" second, legislation which would authorize "Veterans' Job Training Act (VJTA) Appropriations for Fiscal Years 1988 and 1989;" and third, S. 918, the proposed "Veterans' Educational Assistance Improvements Act of 1987." I will come directly to the point of this hearing and address each area of concern in the order stated.

Senate bill, S. 999, the proposed "Veterans' Employment and Training Amendments of 1987" was introduced by the Senate Veterans' Affairs Committee Chairman, Senator Alan Cranston, and cosponsored by Senator Matsunaga and

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VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N. E. ● WASHINGTON, D. C. 20002 ● AREA CODE 202-543-2239

Senator DeConcini. This measure is intended to improve veterans' employment, job training and counseling services and programs. S. 999 would amend Chapter 41 of Title 38, United States Code and the "Veterans' Job Training Act."

Please note that the Veterans of Foreign Wars passed the attached Resolution Number 634, entitled "Veterans' Job Training Act," at our most recent Convention and this resolution clearly outlines suggestions we believe are necessary to improve VJTA.

The Committee should be commended for their innovative approach and many valuable recommendations. However, in our opinion, some additional changes are needed to significantly improve Chapter 41 and adequately fulfill the current employment and training needs of veterans.

The Veterans of Foreign Wars has reviewed the text of S. 999 and we would like to suggest the following improvements:

Sections 1, 2, 3, 7, and 8 are supported by the VFW;
Sections 4 and 6 no objection, however need expansion; and
Section 5 and part of Section 9 does not enjoy VFW support.

Section 1, only identifies the title and does not require any change or addition.

Section 2, would require that Disabled Veterans' Outreach Program (DVOP) Specialists be responsible to State Directors of Veterans Employment and Training (SDVET) and Assistant State Directors of Veterans Employment and Training (ASDVET). The VFW agrees with this requirement.

Section 3, would provide for a more effective utilization of Local Veteran Employment Representative (LVERs). We support this proposal to establish a formula by law that provides for the placement of full-time LVERs in each Employment Service Office. We also applaud the requirement that LVERs be veterans as the law presently does with respect to DVOPs. The VFW passed the attached Resolution Number 679, entitled "Local Veterans Employment Representatives (LVERs)," at our most recent National Convention, our resolution supports this change.

Section 4, is designed to set performance standards for LVERs and DVOPs while establishing accountability. Inasmuch as it is commonly accepted that the Regional Director of the Veterans Employment and Training Service plays a critical role in the administration of veterans' programs and this is the only position not mandated by Chapter 41, we strongly encourage further modification of Chapter 41 to include language providing for this regional administrator's role. Our membership passed the attached Resolution Number 730, entitled "Establishment of Regional Directors for VETS," asking that the Regional Director position be authorized by law.

Section 5, would require that the Secretary of Defense provide the Secretary of Labor and the Administrator of Veterans Affairs the current list of employers participating in the National Committee for Employer Support of the Guard and Reserve (NCESGR) and a monthly update of the NCESGR listing. We suggest that inasmuch as the Assistant Secretary of Veterans' Employment and Training should already be working closely on a routine basis with the NCESGR as well as the Committee for Employer Support of Veterans' Employment from the Veterans Administration, the Small Business Administration, Chambers of Commerce, National Alliance of Business, National Federation of Independent Business and many other representatives of the private sector, it is unnecessary to mandate information already administratively available to the ASVET.

Section 6, would clarify the responsibilities of Employment Service personnel in each of our 50 states. We agree that the DVOPs and LVERs must provide needed counseling services. This service should not be limited to only those specifically applying for VJTA but expanded to allow counseling to all veterans applying for employment and training programs.

Section 7, would establish and make permanent the National Veterans Employment and Training Service Institute (NVETSI). The pilot program initiated by the ASVET has received many favorable reports and the VFW wholeheartedly agrees with the continuance and expansion of this training program. We visualize unlimited potential as this training program becomes a permanent resource of the Department of Labor (DOL) and suggest that funding for NVETSI be established as a separate line item within the ASVET annual budget. This dual purpose program would train employment personnel and also serve as a resource library of employment and training information. The informational material would then become available to any interested state or federal agency. We further note and agree that the current course syllabus needs expanding to provide specific training on vocational and guidance counseling techniques.

Section 8, would require that each VA Regional Office provide the Public Employment Service and the Department of Labor with frequent updates of employers approved for VJTA. The VFW believes that this requirement can only serve to further improve cooperation and coordination between agencies, the employers and the prespective veteran participants.

Section 9, would modify the formula used to reimburse employers participating in the VJTA program. Section 9, also would require that each veteran participant be assigned a case manager and be provided full-related counseling services. The VFW is highly supportive of the case-manager concept and we concur that professional, vocational and guidance counseling is a much needed support service. The Centaur Report indicates that 2/3 of the VJTA training dropouts occurs during the first three months. After reviewing the information concerning voluntary and involuntary terminations, it appears that the vast majority of dropouts were the result of poor performance, absenteeism and emotional difficulties. This data suggests a need for providing better job preparedness to participants by providing a case worker/counselor support system.

Though we agree with the overall intent of Section 9, to reduce the dropout rate, we do not agree with the plan to modify the employer reimbursement formula. Currently, VJTA employers receive 50 percent of the veteran's wages throughout the training period. Employers, according to Centaur, overwhelmingly support the continuation of VJTA, and expressed support for the direct training cost reimbursement. These employers also found the current administration of the program not burdensome. We believe that by establishing a formula system of payment, the program could become cumbersome to oversee and burdensome for the employer; thus, causing potential employers to shy away from participation. Let's continue to encourage employer participation while improving veteran participants job preparedness and adjustment.

The VFW would like to suggest one additional refinement of this bill. In order to ensure program continuity, the current Schedule C Deputy Assistant Secretary for Veterans Employment and Training (DASVETs) should be changed to a career Senior Executive Service (SES) position.

The second main area of concern to be addressed at this hearing is the amendment to authorize VJTA appropriations of $60 million for each of Fiscal Years 1987 and 1988. This change was recently offered as Substitute Amendment Number 160. We have reviewed the entire text of the amendment and the suggested appropriation appears to meet the minimum funding level necessary to continue VJTA. We support funding for this worthy program.

VJTA is the only veterans' employment and training program remaining on the books and, most importantly, VJTA is a proven success at providing a much needed service. The VFW maintains that this program should be fully funded, extended and even expanded as needed to help ensure that the veterans of this nation are given the opportunities they fought so hard to preserve.

Finally, let's take a look at S. 918, the proposed "Veterans' Educational Assistance Improvements Act of 1987," introduced at the request of the Administration. Though the title of this bill cites "improvements" to educational benefits, we found mostly benefit eliminations. Section 102 would eliminate advance payments of subsistence allowances under Chapter 31, Section 103 would eliminate advance payment under the work-study program, and Section 201 would eliminate the VA education loan program. The administration justifies these eliminations by suggesting that these "improvements" would end overpayments and loan defaults in these programs.

The VFW does not believe that needed benefits should be eliminated just to protect the Administration from a few abusers. These benefits have provided may honest and deserving veterans with the financial assistance necessary to pursue a higher education. We will oppose any reduction of educational benefits.

The New GI Bill has proven to be a highly successful program and the VFW is in favor of making it a permanent program, funded by the Veterans Administration. Currently military recruits are automatically enrolled in the program upon enlistment. Section 101 of S. 918 would amend the New GI Bill to require that the recruit declare his/her election not to participate within two weeks of enlistment. Our organization has not been made aware of any problems associated with program enrollments and we therefore hesitate to support legislation that could alter this very workable program.

In conclusion, the Veterans of Foreign Wars supports VJTA and therefore we agree with the intent of S. 999 to improve the VJTA program. We oppose the elimination of worthwhile veterans benefits; therefore, we oppose S. 918.

Thank you.

Resolution No. 634

VETERANS' JOB TRAINING ACT

WHEREAS, the Emergency Veterans' Job Training Act (Public Law 98-77) was enacted to address the problem of severe and continuing unemployment among Korean and Vietnam era veterans, and Public Law 99-238 was enacted to extend and enhance this important Veterans' Employment and Training Program; and

WHEREAS, veterans of the Vietnam and Korean eras continue to endure high unemployment and experience difficulties in obtaining meaningful employment; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we request the Congress of the United States to:

1. Extend the Veterans' Job Training Act initial applications and training deadlines until November 30, 1991 and December 31, 1991, respectively.
2. Change veterans' eligibility, reducing the period of unemployment from 10 of the preceding 15 weeks to 5 of the preceding weeks.
3. That adequate funding be authorized and appropriated to the Veterans Administration and that these funds remain available through December 31, 1992.
4. That out of the total appropriation, administrative funds be allocated for the purpose of conducting outreach to promote awareness of the veteran and the employer communities.
5. Enact legislation to include within Veterans' Job Training Act provision for vocational education programs to be provided through December 31, 1991.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 634

Resolution No. 679

LOCAL VETERANS EMPLOYMENT REPRESENTATIVES (LVERS)

WHEREAS, Section 2004, Chapter 41, of Title 38 United States Code, which in part describes the qualifications of the Local Office Employment Representative reads "--- preferably an eligible veteran," thus making it possible for a nonveteran to fill this strictly veteran related position; and

WHEREAS, the current ASVET policy causes continual fluctuations in the number of LVER positions and has adversely impacted upon the employment services provided to veterans; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we seek to change Section 2004, Chapter 41 of Title 38 United States Code, by deleting the phrase "preferably an eligible veteran" and substituting the phrase "must be an eligible veteran" in its place; and

BE IT FURTHER RESOLVED, that we seek legislation to change Section 2004, Chapter 41, Title 38 United States Code to support the assignment of full-time LVERS based upon the local office area population of 6000 veterans and/or 1000 new and renewal veteran applications each program year in order to provide a stable staffing level for their positions.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 730

ESTABLISHMENT OF REGIONAL DIRECTORS FOR VETS

WHEREAS, the Congress of the United States enacted legislation providing for a Veterans' Employment and Training Service within the U.S. Department of Labor; and

WHEREAS, Chapter 41, Title 38, U.S. Code, provides that the VETS shall be responsible for job training, counseling and placement service for veterans to be administered by an Assistant Secretary of Labor for VETS; and

WHEREAS, the Regional Veterans' Employment Representatives have been appointed, although not authorized by law, to supervise the State Directors and Assistant State Directors for the VETS in their respective regions in serving veterans; and

WHEREAS, the Regional Veterans Employment Representative, with secretarial assistance, provide a most necessary service in carrying out the mandates of Congress to serve veterans; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we go on record petitioning the Congress of the United States to enact legislation to amend Chapter 41, Title 38, U.S. Code, to establish the Regional VETS Representative by law.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 730

Statement of

James G. Bourie

National Service Director

AMVETS

Before the

Veterans Affairs Committee

U.S. Senate

on

S999: Veterans' Employment, Training and
Counseling Amendments of 1987

S_____: Funding of the Veterans' Job Training Act

and

S918: Veterans' Educational Assistance
Improvements Act of 1987

April 30, 1987

Mr. Chairman, the American Veterans of World War II, Korea and Vietnam (AMVETS) thanks you and this Committee for the opportunity to express its views on S999: Veterans' Employment, Training and Counseling Amendments of 1987 which would make several amendments as to how veterans' employment and training services are provided under Section 41 of title 38, U.S.C.

Before we begin, AMVETS wishes thank and compliment this Committee for its active concern over the pressing issues of veterans' employment and training. Under your direction Mr. Chairman, AMVETS looks once again to your leadership and pledges its full cooperation and support.

Regardless of official statistics, veteran employment issues are real, for veterans of all eras and especially the disabled veteran. Also, a disproportionate share of the homeless and displaced workers are veterans and in times of economic down-turns, Vietnam era veterans are usually the first to be laid-off.

Over the years a plethora of programs and services have been enacted to assist veterans find gainful employment. Some have been successful, but short-lived; still others were abject failures. One victory was certainly the hard fought establishment of the position of Assistant Secretary for Veterans' Employment and Training Service to coordinate and control all veterans' employment and training programs within the Department of Labor.

In retrospect Mr. Chairman, the veterans service organizations and their Congressional allies have fought hard over the years for responsive and substantive veterans employment and training programs, it was always an uphill fight. It is most disappointing and frustrating that when it comes to federal employment and training programs, veterans are not included; not included in any meaningful way in the Job Training Partnership Act; not included in any of the Administration's employment and training proposals. We must fight for every inch, yet it is often a losing battle.

We hope that S999 will help in the administration of veterans' employment and training programs and services. AMVETS does not oppose Disabled Veterans Outreach Program Specialists (DVOPs) being functionally responsible to the State Director for Veterans' Employment and Training Service. In fact, it is a logical move since many DVOPs are utilized in a non-DVOPs role and, like the Local Veterans Employment Representative (LVERs) in many Job Service offices, used for non-veteran work. We also have no objections regarding the LVERs; the placement ratio; functional responsibility; counseling Veterans' Job Training Act eligibles. We especially support veterans' preference of LVERs; the exclusivity requirement and the tighter administrative controls on LVER funding.

AMVETS further supports the evaluation performance of LVERs and the uniform performance standards for both LVERs and DVOPs with monitoring provided by the Veterans Employment and Training Service (VETS). However, we must caution not to become too uniform; that is, LVERs and DVOPs must be judged by differing program performance standards. Differing local economies must also be taken into account. It is a good proposal to have LVER and DVOP performance monitored by the VETS.

There is no reason why the Department of Defense (DOD) should not be included in the promotion of veterans' employment and training services through whatever sources it has at its disposal. A representative of the DOD attends the Secretary of Labor's Veterans' Employment Committee and there have been certain joint activities with the National Committee for Employer Support for the Guard and Reserve (NCESGR). On a more formal basis, AMVETS does not object to the DOD supplying both the Department of Labor and VA with the NCESGR employer list on a monthly basis. There might, however, be some delay or confusion as to what those agencies are suppose to do with the list, as well as the logistical and administrative difficulties that might arise.

With regard to veterans' employment and training measures under the Veterans' Job Training Act (VJTA), we have no objections, and indeed endorse the idea wherein the Secretary for Veterans' Employment and Training Service take a more active role in VJTA registration and placement as well as having DVOPs counsel eligible participants. All veteran service providers need to take a more active and aggressive hand in the Job Training Partnership Act (JTPA) as far as veterans are concerned as veterans are left out of the JTPA mainstream.

Mr. Chairman, AMVETS knows first-hand of the excellence of the National Veterans Training Institute (NVTI). We have been a presentor and have otherwise kept abreast of the NVTI's progress. It is an outstanding program with dedicated and committed staff under the capable leadership of Mel Cozzens, its director. If nothing else, the NVTI needs to continue on a permanent basis, and we applaud this Committee for taking those steps. However, there is no provision for continued funding. We recommend amending language to attach the NVTI to the Office of Assistant Secretary for Veterans' Employment and Training and that the NVTI be made a permanent and identifiable part of the OASVETS' budget submission. Otherwise, while on the books the NVTI may not be funded. This has happened to good programs in the past.

We agree and support the provisions Mr. Chairman that would make the VETS, to include DVOPs and LVERs, more administratively responsible and active in the providing of services and programs. The VETS is now the perhaps least federal program for information flow and management, although the ASVET is currently rectifying that situation. DVOPs, LVERs and others are not now held really accountable for services and some veteran service data either is of no real use or is not shared on a national basis.

In all Mr. Chairman, AMVETS is supportive of the thrust of S999 but cautions not to attempt to manage all veteran services and programs through legislation. We certainly do not want the field manager's hands tied, or for that matter program managers. We suspect that if this legislation passes, some local Job Service office managers (and some state administrators) will have their noses out of joint as they will be required to utilize DVOPs and LVERs for exclusive veteran services, an elite cadre of professionals. That sort of situation must be watched closely by the VETS for compliance. DVOPs and LVERs remain state employees and S999 will be of little use or protection in some local offices. The ASVET will need to take a strong hand with some of the state administrators when found out of compliance--no idle threats, but swift action. There might also be the problem of additional funding and staff needs to administer many of S999's provisions, and we are not at all certain whether the department or OMB will approve additional OASVET funds. Mr. Chairman, hopefully, Amendment 160 to S.999 which you introduced on 24 April 1987, authorizing $60M for the VJTA for each of the next two fiscal years and extending the deadlines for application and participation in the programs to June 30 and December 31, 1989 respectively will effectively address this contingency.

As an additional recommendation Mr. Chairman, AMVETS would like to see Section 2010(b)(1) Secretary of Labor's Committee on Veterans' Employment be amended to include the U.S. Postal Service and the Secretary of Education. Both are concerned, in many ways, with veteran issues.

On the matter of S___ which would authorize Veterans' Job Training Act appropriations of $60 million for each fiscal years 1988 and 1989, AMVETS supports the measure as we are totally supportive of the program. We would, nonetheless, like to see the program opened to include veterans of all eras who meet the unemployment criteria. We would also like to see a small portion of the amount appropriated used for administration and a small portion retained for perhaps outreach or other direct veteran activities or programs.

With respect to S918: Veterans Educational Assistance Improvements to Chapter 30 of Title 38, U.S.C., better known as the New GI Bill. As you will recall Mr. Chairman, AMVETS was one of the first veterans service organizations to endorse and promote legislation for a "New GI Bill." We still support the program and will support amendments that will improve the program in a fashion commensurate with its intent.

As we review the proposals of S918, we find no disagreeing features and thus support its passage.

Mr. Chairman, we have attempted to cover a lot of ground and sincerely hope that our comments will be of some help to the Committee.

Thank you for allowing AMVETS the opportunity to appear.

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STATEMENT

of

RICHARD F. WEIDMAN

Director of Government Relations

VIETNAM VETERANS OF AMERICA

on
S.999 - "Veterans Employment, Training,
and Counseling Amendments

Before the

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES SENATE

APRIL 30, 1987

Mr. Chairman, Vietnam Veterans of America (VVA) appreciates this opportunity to present our views here this morning on issues affecting delivery of employment and training services to veterans, particularly Vietnam theatre and disabled veterans. As you and your distinguished colleagues are keenly aware, the opportunity to secure meaningful employment is an inextricable and key element of readjustment counseling. We are deeply grateful to you for your early and strong leadership in this area. VVA applauds these latest efforts to solidify the structure of service delivery to ensure that veterans in need of employment placement services receive such services, and that those who are in need of training and/or supportive services in order to gain employment similarly receive such services in an effective and timely manner.

In regard to S. 999, Vietnam Veterans of America generally supports the proposed "Veterans Employment, Training and Counseling Amendments of 1987." This proposed legislation is basically an effort to strengthen Chapter 41 of Title 38 of the U.S. Code, an effort that VVA fully endorses. Two major weaknesses of Chapter 41 have become increasingly clear in the last six years, that need be directly and forcefully addressed. The lack of statutory definition of the purpose, duties, and particularly the lack of a mandated number of Local Veterans Employment Service Representatives (LVERs) based on population of veterans served has left this program vulnerable to arbitrary cuts by the Office of Management and Budget (OMB). This is addressed in Section 3 of S. 999, which mandates a formula for funding LVERs based on numbers of veterans seeking services, in a manner similar to that previously existing for Disabled Veteran Outreach Program Specialists (DVOPs). VVA strongly endorses this approach. The current Administration has tried, (unfortunately somewhat successfully,) to greatly diminish the LVER program in each of the last five proposed budgets.

The second aspect of Chapter 41 that is addressed to some degree in S. 999 is the question of adequate authority and accountability of personnel funded by the U.S. Department of Labor for performance of duties serving veterans at the service delivery level. Essentially the Assistant Secretary of Labor has not had adequate control over DVOPs and LVERs, who are the ones who actually deliver a major part of the services mandated under this Title. This means that the Assistant Secretary of Labor for Veterans Employment and Training (ASVET) has not had sufficient authority as to be commensurate with ASVET responsibilities. S. 999 moves in the right direction of giving Veterans Employment and Training Service (VETS) personnel functional control and monitoring of performance evaluation of DVOPs and LVERs by means of standards developed by the Secretary of Labor. VVA would point out that this strengthening of the authority, as well as of the elements and standards attached to federal funding of these programs, will only be effective if in fact there is genuine commitment on the part of the Secretary of Labor to hold states accountable for ensuring that DVOP and LVER personnel are properly trained, supported, and allowed to do their jobs. Specifically we are referring to our belief that many of these personnel have not been trained and are not supported properly by the Employment Service within which they work. Further, VVA still receives complaints from DVOPs and LVERs that they are forced to spend time dealing with non-veteran clients and/or non-veteran related functions. More effective monitoring and evaluation of the actual time spent performing specific tasks is needed. More determination to use the management tools by DoL is also needed. The proposed provisions, if utilized properly, should largely meet this need.

VVA is extremely supportive of the provision that would legitimize the existence of the "National Veterans Training Institute" (NVTI). The creation of NVTI is one of the most important developments for veterans at the Department of Labor in the past ten years. VVA suggests that you consider going even further with this provision to mandate that NVTI be funded at a level adequate to maintain current levels of activity while expanding the training programs offered as would be appropriate to train all U.S. DoL funded personnel in their special responsibilities toward veterans, particularly special (ie. service connected) disabled veterans. It should be noted that over half of the services provided by the State Employment Services (S.E.S.) to veterans are provided by personnel other than DVOPs and LVERs. It is worth remembering that the DVOP and LVER programs were created to assist the State Employment Services in doing a better job of meeting the needs of veterans, not to bear the entire brunt of the task. Therefore, NVTI training for DVOPs, LVERs and VETS personnel as crucial as it is, only meets part of the need. Training "packages" that can be delivered to S.E.S. personnel in a given state is the next logical step of assisting people in understanding their job in regard to veterans and how to accomplish that job more effectively.

In regard to "Sharing of Information Regarding Employers" (Section 8), VVA urges the Committee to examine the possibility of requiring the Secretary of Labor and the Veterans Administrator to report on a regular and recurring basis to the Congress with a specific and thorough performance evaluation of cooperation and coordination efforts between the two agencies. It is clear that the "Interagency Working Agreement" signed in the summer of 1984 has not achieved the level of desirable coordination between VA and VETS personnel at either the national, regional, or local level. As you are aware, Mr. Chairman, significant employment problems are reported by almost half of the veterans seeking help from Vet Centers, operated by the Readjustment Counseling Service of the Veterans Administration. The inter-related nature of employment problems and readjustment counseling seems to be well established to any who will take the time to consider this area of concern. VA and DoL can and must do a better job of working together at every level.

Mr. Chairman, Vietnam Veterans of America would suggest that you consider adding a provision as part (a)(5) under Section 2009 of Chapter 41 to the effect that "the Secretary shall:

"5. ensure that the special needs of combat theatre and disabled veterans are fully addressed by all training programs administered by, or funded by the U.S. Department of Labor, and that elements and standards be promulgated for all such programs to ensure and monitor compliance with the provision."

One of the major difficulties with the current structure is that unless veterans are specifically "written in" to legislation at the Federal level, veterans are specifically "read out" of employment and training programs at the state and local level. This is particularly true in regard to training programs such as the Job Training Partnership Act (JTPA), at least in the major titles. The above suggested provision, (or one akin to it) would clarify that it is the express intent of the Congress that veterans be fully and properly served, particularly those combat theatre and disabled veterans with special needs.

VVA would further suggest to the Committee that you consider mandating the positions of "Regional Directors of Veterans Employment and Training." The duties of the RDVETS would be to oversee, on a regional basis, all U.S. Department of Labor administered and U.S. DoL funded programs. As long as this is not a statutorily mandated position, the positions of RDVETS will be in constant jeopardy of elimination as ostensible "cost savings" measures. In fact, the RDVETS are a key link in the chain of command for the Assistant Secretary of Labor. Without effective presence at the Regional Office level it is unlikely that the concerns of veterans will be considered properly by the "Employment and Training Administration," among other programs administered under the U.S. Department of Labor. As you are aware, there were RDVETS in each of the ten U.S. DoL Regional Offices at the beginning of this Administration. That number has since been reduced from ten to seven, and is subject to further cuts as the situation now stands. We urge that the Committee move to ensure that these key links in an effective Veterans Employment and Training Service be preserved, by law.

The Bureau of Labor Statistics, U.S. Department of Labor, published a study of Vietnam theatre and service connected disabled veterans on March 31, 1986. That study documented what many in the veterans community had been maintaining for years in that it found that Vietnam theatre veterans and service connected disabled veterans were much less likely to participate in the labor force, and much more likely to be unemployed if they were still in the labor force. Producing similar data on a regular and recurrent basis, on at least an annual if not a semi-annual basis, was unanimously recommended by the Secretary of Labors Committee on Veterans Employment at the regular quarterly meeting of January 15, 1987. VVA respectfully suggests that a part (d) be added to Section 2007 to the effect that:

> "The Secretary of Labor shall cause the Bureau of Labor Statistics to regularly gather information on labor force participation and employment and unemployment rates among special disabled veterans and veterans who served in the Vietnam theatre of operations. The Secretary shall report to the Congress annually all such information, and shall consider such information in formulation of legislative recommendations as well as administrative initiatives within the parameters of other subsections of this Title."

VVA would further urge the Committee to favorably consider what is known as the "residency requirement" for persons applying for State Director of Veterans Employment and Training (SDVETS) positions. This requirement is contained in Section 2003, part (b)(1)(A) of Chapter 41. VVA would suggest simple deletion of the words "who at the time of appointment has been a bona fide resident of the State for at least two years." Mr. Chairman, much progress has been made by the Veterans Employment and Training Service (VETS) in recent years to professionalize the agency. More and better training of VETS personnel has been instituted. The VETS is now in the process of implementing a solid management by stated objectives system that should serve to further rationalize and improve the system. However, the anachronism of the residency requirement precludes advancement of talented Assistant State Directors of Veterans Employment (ASDVETS), particularly in large states like California. Frankly, preservation of the residency requirement may in fact be a vestige of what some have charged in the past was a semi-patronage system. In any case, VVA strongly urges the Committee to either eliminate it altogether or modify it so as to allow ASDVETS from other states to apply for vacant SDVETS positions.

In regard to Section 2009, part (b) of Chapter 41 of Title 38, the Secretary of Labor is required, pursuant to Public Law 97-306, to submit an annual report detailing the effectiveness of all Department of Labor programs in meeting the goals of each subsection as defined in the legislation. If such a detailed report has been submitted, it seems to have escaped the notice of those of us in the veterans service organizations who are interested in these issues. Of particular interest is the mandate for "such recommendations for further legislative action relating to veterans' employment as the Secretary considers appropriate." To our knowledge this Administration has yet to propose any legislation in regard to meeting the special employment and training needs of Vietnam theatre and service connected disabled veterans, or of veterans in general.

Vietnam Veterans of America strongly supports the proposed extension of the Veterans Job Training Act (VJTA). VVA would, however, suggest that there is merit in extending the authority for this program for at least three years. For over a decade there has been a general tendency to regard employment problems among veterans as being transitory in nature. It is abundantly clear to VVA that significant unemployment and underemployment problems persist on a continuous basis among special disabled and Vietnam theatre veterans. Efforts to assist these veterans have been greatly hampered by the "start-stop" nature of programs like VJTA. Indeed, the credibility of VJTA itself has been somewhat hurt by the interruptions in both funding and authority. Yet this program remains a valuable tool to assist "difficult to place" veterans. Therefore, with the counseling and case management approach mandated in Section 9, part (b) this program should be extended for another three years.

VVA does have some reservations about Section 9, part (a) "Payments to Employers." It has been our experience in any sort of disbursement program that the best program is the one with the simplest and most straightforward methology. While VVA endorses the motivation behind part (a) of rewarding employers for successfully assisting veterans through the program to completion, we fear that the proposed part (a) will only result in confusion and resentment among employers. It is the belief of VVA that the way to reduce the "drop-out" rate is active case management and delivery of supportive services to participants, especially in the first ninety days of their participation in the program.

In summation, Mr. Chairman, Vietnam Veterans of America strongly supports S. 999, and wishes to thank you for your continued leadership for veterans employment and training initiatives as a crucial element in readjustment counseling. VVA would hope that the aforementioned suggestions are of some use to you in making S. 999 an even stronger proposal.

Thank you for the opportunity for Vietnam Veterans of America to present our views before the Committee today.

BLINDED VETERANS ASSOCIATION
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THE BLINDED VETERANS ASSOCIATION REMARKS ON
S. 999
"PROPOSED VETERANS EMPLOYMENT, TRAINING, AND COUNSELING AMENDMENTS OF 1987."
AS PRESENTED BY
EXECUTIVE DIRECTOR RONALD L. MILLER, PH.D.
BEFORE A HEARING OF
THE SENATE COMMITTEE ON VETERANS' AFFAIRS

APRIL 30, 1987

CHARTERED BY THE CONGRESS OF THE UNITED STATES

Mr. Chairman and Members of the Committee:

On behalf of National President Robert Routh Jr. and the membership of the Blinded Veterans Association (BVA), I am pleased to present written and oral remarks on S. 999, "Proposed Veterans Employment, Training, and Counseling Amendments of 1987." The BVA has supported and will continue to support the continuation and improvement of all employment, training, and counseling services as now exist under the unique federal-state relationship between the U.S. Department of Labor (DOL) through the Office of the Assistant Secretary of Labor for Veterans Employment and Training (ASVET) and the public employment services.

The BVA has long felt that a significant revision of Chapter 41 of Title 38 U.S. Code was overdue. The proposed amendments to Chapter 41 appear to address the deficiencies discussed by federal and state employment personnel, members of Congress, and the veteran service organizations. The proposed amendments have the potential to improve the delivery of such services to veterans and to establish a more effective and accountable relationship between the DOL/ASVET and the State Employment Security Agencies (SESAs). The revision should also increase the cooperation and coordination between DOL, the SESAs, the Veterans Administration (VA), and the Department of Defense (DOD). If implemented properly, the newly amended Chapter 41 can be the basis for significantly enhancing the quality and quantity of employment opportunities available to America's veterans.

The success of the Disabled Veteran Outreach Program (DVOP), first under the Comprehensive Employment and Training Act (CETA) and subsequently permanently established in Chapter 41, has received justifiable recognition for the last ten years. After its codification, the duties and responsibilities of the DVOPs have continued to evolve. However, because of the unique federal-state relationship, there has been an ongoing problem of misuse and occasional abuse in the assignment of duties for the DVOPs. Although the need for greater supervision of the DVOPs by the State Directors for Veterans Employment and Training (SDVETs) and Assistant State Directors for Veterans Employment and Training (ASDVETs) is beyond question if the DVO Program is to remain an integral and viable service delivery system. There will undoubtedly be concern on the part of the SESAs that increased supervision by the SDVETs and ASDVETs will interfere with the existing state personnel guidelines and procedures. Similarly, in proposing to amend Section 2004 of Chapter 41 to require the Local Veterans Representatives (LVERs) to be "functionally responsible" to the SDVETs and/or the ASDVETs may also cause concern among the SESAs. To dispel their concern and to alleviate future confusion in the implementation of this proposed amendment, the term, "Functionally responsible," should be more clearly defined.

The BVA has long desired a more specific statement in Chapter 41 regarding the formula for the establishment of LVER positions in the fifty states. The proposed formula will undoubtedly ensure that there will be sufficient veterans program staff to serve the employment, training, and counseling services for veterans. Negotiations to implement this provision between the ASVET through the SDVETs and the SESAs will be necessary to ensure that the allocation of personnel resources are equitably assigned. For example, basing the LVER assignment on either the number of veteran registrations in the Local Office (LO) or on the veteran population in the LO's administrative area may cause staffing problems, especially in large employment offices in metropolitan areas.

Additionally, serious consideration must be given during these negotiations to determine if veteran applicants will be channeled through the "mainstream" selection and referral process in the LO or if the LVERs and the DVOPs will provide these services as a "Veterans Unit." With the existing and now proposed additional responsibilities, it would appear that the LVERs and DVOPs will not be able to serve every veteran. The practice in many states has been to have Placement staff make the necessary selection and referrals for job ready veterans, while the DVOPs handled the disabled and those in need of vocational counseling or training referrals. Historically, the assignment of LVERs and DVOPs, to a degree, have often been based on the immediate financial exigencies of the SESAs. Requiring a uniform allocation formula, the appointment of veterans as LVERs and to have them exclusively serve veterans will go a long way toward eliminating unintentional or deliberate misuse.

Requiring the SESAs to base their LVER funding projections on the proposed formula will ensure the appropriate staffing allocations. It must be noted, however, that some states use a different accounting system in determining the cost of a fulltime equivalent and consequently, their funding projections may differ from those of DOL. DOL and the SESAs should be required to adopt the same accounting methodology for their projections.

As important as the LVER allocation and appointment requirements are, the development and implementation of uniform performance standards for LVERs and DVOPs is essential. SESAs can be required to comply with funding projections and veterans can be appointed to serve as LVERs, but unless the LVER, the DVOP and the LO manager and supervisors do not know the specific duties and responsibilities of the veteran program staff, there will continue to be misuse of these resources. The standards must be uniform but flexible enough in structure to meet the needs of the LO veteran population. Requiring the SDVETs and ASDVETs to be directly in the formulation of each LVER's performance rating through his comments to the LO supervisor is not as radical as it may first appear. Many SDVETs and ASDVETs have made it a practice to review and comment on the performance of the LVER and the DVOPs during their LO evaluation of veteran services. It will be incumbent upon the ASVET to provide sufficient information and guidelines to the Veterans Employment and Training Staff (VETS) to ensure that proper personnel procedures are observed and that the individual's rights and state personnel codes are not violated.

If there has been one area in which the public employment service has failed its veteran applicants, it is in its inability to provide adequate and quality counseling services. The proposed amendment here will go a long way in ensuring that the veteran will receive the needed vocational counseling. Some states have already made provisions to train LVERs and DVOPs as Vocational Counselors, realizing that they are the best source for meeting this deficiency. Problems have arisen, however, because of the reluctance of state personnel agencies and professional counseling groups to allow the LVERs and

DVOPs without Bachelor degrees to be classified as Vocational Counselors. The adoption of this provision may provide the necessary impetus to the SESAs to obtain changes in the state personnel codes.

From all that we have heard, the pilot project establishing the National Veterans Training Institute (NVTI) has been very successful. We firmly support the amendment that would codify the NVTI as a permanent training institute for VETS staff, LVERs and DVOPs. Along with training in case management, counseling practices and resource networking, we recommend that the federal and state staff be given further training to develop greater sensitivity to and understanding of the capabilities of the severely disabled veterans and their unique employment needs. The increased sensitivity must be accompanied with the recognition by all levels within the veterans employment services delivery system that counseling, job development, and placement of this category of veteran is time consuming. Such services, however, are at the heart of the veterans programs.

The proposed amendments in Sections 5 and 8 requiring the DOD and the VA to share their lists of employers with the DOL/VETS and the SESAs on a regular basis would be helpful. The DOD list from the National Committee for Employer Support for the Guard and Reserve (NCESGR) would not only provide the veteran staff with greater placement possibilities with this group of dedicated employers but also increase the contacts with the "citizen soldiers" of the Guard and the Reserve. Similarly, requiring the VA to supply DOL/VETS and the SESAs with its approved Veterans Job Training Act (VJTA) employer list from each VA Regional Office will also enhance the employment opportunities for all veterans.

The BVA supported the adoption of the Emergency Veterans Job Training Act and wholeheartedly endorse the proposed amendments in Section 9 to the VJTA. As successful as this program has been, the greatest drawback has been the failure of 40% of the trainees to complete their program. Speeding up the employer reimbursement and offering a cash incentive for completion of the veteran's training program should reduce the numbers failing to finish.

The BVA believes that the revision of Chapter 41 will go a long way toward improving the effectiveness and accountability of this joint federal-state partnership. The amendments will enhance the quality and timeliness of employment training opportunities for all veterans. The proposed changes to the VJTA will undoubtedly preserve and increase the success of this program. The changes in the reimbursement formula and establishment of greater coordination between the DOL/VETS, the VA, and the SESAs offers increased job opportunities, participation and retention of veterans in the training programs.

# # #

PVA

PARALYZED VETERANS
OF AMERICA

STATEMENT OF

BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

VETERANS ADMINISTRATION'S EDUCATION AND EMPLOYMENT PROGRAMS

APRIL 30, 1987

Mr. Chairman and Members of the Committee, on behalf of the members of Paralyzed Veterans of America, I want to thank you for this opportunity to present our views regarding several of the Veterans' Administrations Education and Employment Programs; I am Bob Moran, PVA Associate Legislative Director.

At the outset, PVA would like to commend you, Senator Cranston as Chairman of the Committee, for holding this hearing. Additionally, we wish to further compliment you and each individual Member of the Committee for your efforts to examine and evaluate the VA's Education and Employment Programs which are of importance to our nation's veterans.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300
Chartered by the Congress of the United States

PVA supports S. 999, the "Veterans' Employment and Training Amendments of 1987," introduced by you Mr. Chairman, and also supports your amendment to S. 999, Amendment No. 160. This legislation would improve veterans' employment, job training, and couseling services and programs under Chapter 41 of title 38, United States Code. Additionally, the legislation would extend the deadlines governing applications and entry into the Veterans' Job Training Act (VJTA) and would authorize appropriations for Fiscal Years 1988 and 1989. As you know, the VJTA came into being as a result of Public Law 98-77, enacted in 1983, in response to very high veteran unemployment that existed at that time.

From the information that has been compiled over the course of the program, and despite its slow start, the VJTA program has been responsible for the issuance of Certificates of Eligibility to over 460,000 veterans, and over 70,000 employers have had training programs certified as acceptable, which constitutes a potential market of over 164,000 new jobs for veterans.

The Veterans Administration and the Department of Labor have shared joint responsibility for the implementation of this program, and both agencies agree that the VJTA has been a very successful endeavor. To date, over 52,000 veterans have been successfully matched to prospective employers. PVA believes that the VJTA is beginning to fulfill, to its potential, the promise of successfully placing veterans into government-supported, employer-conducted, work training programs. And, as the statistics demonstrate, work training programs such as the VJTA are leading veterans into full-time employment positions.

Mr. Chairman, the goal of the VJTA is to address the problem of severe and continuing unemployment among certain groups of veterans by providing payments to defray the cost of training to employers who hire and train these veterans. The VJTA has done just that, having assisted over 52,000 long-term unemployed veterans into returning back to work. Additionally, veterans who are employed under VJTA immediately become tax payers, not tax users, thus benefitting all Americans. The VJTA program should be extended and again I would like to commend you Mr. Chairman and each Member of the Committee for your interest and concern for such a most worthwhile program.

And lastly Mr. Chairman, I would like to comment on S. 918, the "Veterans' Educational Assistance Improvements Act of 1987," legislation requested by the Administration. PVA is concerned with Section 102, contained within S. 918, a provision which would eliminate the authority to make advance payments under Chapter 31, the VA's vocational rehabilitation program. Under current law, certain veterans are eligible to receive subsistence allowances under Chapter 31, and may upon request, be provided an advance payment equal to as much as two months subsistence allowance prior to actual entry into a program of vocational rehabilitation.

These advanced payments are intended to assist veterans with the initial expenses incurred with starting an educational program. For some disabled veterans, before being able to start training they are faced with a variety of added expenses such as transportation, clothing, and other personal readjustment expenses, not to mention their living expenses during the initial periods of training.

To deny this particular category of eligible veterans this benefit, one which could determine the success or failure of their vocational training program, we believe is unwarranted and unwise.

In conclusion Mr. Chairman, the importance of viable veterans' employment and training programs, if placed in proper perspective, are critical parts of the overall well-being of one's life, and can and should be viewed as the pinnacle of the veteran's health-care continuum. Jobs are important in an individual's self perception. If a veteran does not have a vocation, a job, this can and often does give rise to various health maladies that can accompany the sometimes lowered self-esteem that goes hand-in-hand with one's unemployed condition.

We cannot deny the fact that, in our society, even as welfare-oriented as some may have us believe we have become, we still place a very high value on the work ethic - that each person should, to the best of his or her own personal ability, perform certain duties and/or activities that lead to the betterment of themselves, their family, and society in general. Most of us, from the time we are born, have a work-related responsibility to ourselves, to our loved ones, and to the country in which we were born. A veteran, more than most Americans, knows full well this fact of life.

This concludes my statement and I would be glad to respond to any questions that you might have. Thank you.

Department of Medicine and Surgery Washington D.C. 20420

Veterans Administration

JUN 2 1987

In Reply Refer To: 10A41A

Honorable Alan Cranston
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510-6375

Dear Mr. Chairman:

I am responding to your letter of May 8, 1987, relating to matters arising during your oversight hearing of April 14, 1987.

At this juncture, I cannot provide a comprehensive response to each of the ten questions you posed concerning the Hawaii initiative. When the Hawaii Veterans Health Care Task Force completes its task in mid-July and the Department considers its recommendations, I will provide you a full report on our plans and other pertinent developments. This report will contain responses to each of the questions in your letter.

Let me briefly bring you up to date regarding our initiative. I have appointed the Hawaii Veterans Health Care Task Force as of May 11, 1987. Miss Marjorie R. Quandt, our Director of Strategic Planning, is chairing the group, which has a broad and representative membership from within the Department. A copy of my memorandum listing the Task Force membership and describing its charge is enclosed. The Task Force has established an implementation schedule and work plan, also enclosed, and held meetings here in Washington on May 22 and in San Francisco on May 26. The Task Force will consider the full range of alternatives for patient care, and will consult with University of Hawaii staff about relevant issues and options, such as those you mentioned in your letter. The Task Force is now in Hawaii, and we will also be consulting with VA staff of Guam and the Philippines. The Task force will also take into account the health care environment of American Samoa. In this manner, the effort will help us gain the broadest possible insight about the health care challenges confronting Pacific Basin veterans and the VA system of care.

Regarding beneficiary travel, we do not consider travel pursuant to outpatient treatment as an interfacility transfer for reimbursement purposes. We will, however, continue to authorize payment for travel from contract inpatient facilities to other inpatient facilities under VA auspices. We are now reviewing the relevant regulation to provide relief to veterans residing in the neighbor islands where air travel is necessary to obtain care.

"America is #1—Thanks to our Veterans"

2.

Honorable Alan Cranston

I am confident we will complete our work on this Task Force at an early date, and that it will offer both the Veterans Administration and the Congress valuable options for resolving the key issues concerning health care for veterans in Hawaii.

Sincerely,

John A. Gronvall

JOHN A. GRONVALL, M.D.
Chief Medical Director

Enclosures

Veterans
Administration

Memorandum

Date MAY 1 1 1987

From Chief Medical Director (10A4)

Subj Appointment of Hawaii Veterans Health Care Task Force

To Key Staff Officials

1. In testimony before the Senate Veterans' Affairs Committee on April 14, 1987, I informed the Committee Chairman of my intention to appoint a special task force to review the Hawaii veterans health care situation and to recommend to me the proper course for the Department to improve our response to current and future health care demands. To that end, the purpose of this memorandum is to appoint the Hawaii Veterans Health Care Task Force.

2. Task force membership is as follows:

Name	Organization
Marjorie R. Quandt (Chair)	Strategic Planning (10A4)
Robert Neary	Office of Facilities (08)
Kenneth Clark	Western Region (10BA6)
Terrence Hobbs	Western Region (10BA6)
Kendall Posey	Administration (136B)
Eugene Zuchowsky, Ph.D.	Chief, Psychology Service VAMC, Palo Alto, CA
Paul Errera, M.D.	Clinical Affairs (116)
Arthur Blank, M.D.	Operations (10BRC)
Robert E. Lindsey, Jr. (Ex-Officio)	Operations (10BA)
William Vandervort, M.D. (Ex-Officio)	Director, OPC, Honolulu, HI

3. I charge the Hawaii Veterans Health Care Task Force to concern itself with the following endeavors:

o carefully examine issues and trends affecting Hawaii veterans and the delivery of health care services to them, with particular regard to utilization rate disparities separating the Hawaii experience and that of veterans' medical care on the mainland;

o assess the variety, adequacy and distribution of community health care facilities on Oahu and the outer Hawaiian Islands as well as other Pacific Basin islands;

o analyze the demographic effects now, and those projected to occur in the future;

o consider what should be VA's overall direction in respect to a continuing relationship with Tripler Army Medical Center, especially as it relates to the "E-Wing" commitment;

2.

Key Staff Officials

- explore the possibility of establishing short- or long-term relationships with private sector providers to meet veterans' health care needs, either in supplementation to Tripler-provided services, or to replace them; and

- develop and recommend to me the best array of services and programs aimed at meeting veterans' needs in accordance with their statutory eligibility.

The above particulars are not intended as an exhaustive list, but should be considered guidelines for work by the task force. A number of other areas need exploration, many of which are known already by task force members. All should be explored and resolved.

4. Offices here in Washington and in the field may be called upon to support the work of the task force, and I ask full, continuing cooperation. I have promised the Senate Committee that I will consider the task force's recommendations within the window of opportunity of the FY1989 budget formulation period. In order to keep that promise, I need a final report from the task force, including all necessary concurrences, by July 10, 1987.

5. Any programmatic reviews, work groups, or other planning activities underway presently concerning Hawaii should report their work through the Chair of this task force. Any travel required of field personnel and Central Office staff will be supported by the Director, Strategic Planning.

John A Gronvall
JOHN A. GRONVALL, M.D.

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FROM THE OFFICE OF EXECUTIVE
COMMUNICATIONS (101B)
DATE 05/14/87

IMPLEMENTATION PLAN FOR HAWAII TASK FORCE

5/11 - 5/12 Finalize implementation plan, assign responsibilities for tasks.

5/11 - 5/22 Initiate data/information development and collection efforts.

- -- CMD memo appointing task force
- -- Hawaii Congressional hearing package
- -- Demographic data, projections
- -- VA Hawaii workload data (from VACO, Honolulu, San Francisco, Seattle)
- -- Hawaii vs. U.S. utilization rates
- -- List of Hawaii health care facilities, maps with locations
- -- DOD facility data
- -- Summary of key Hawaii issues
- -- Key correspondence, studies
- -- Cost data

Development of Protocol Materials

- -- Task force objectivies
- -- Options for acute inpatient, outpatient, extended and non-institutional care
- -- Criteria for evaluating options

Conference call - outer island subgroup of task force

Decide on specific site visits, itinerary, tasks in Hawaii. Request Honolulu OPC make arrangments

5/22	Task force orientation meeting in VACO, Washington, D.C.
5/26	Task force travel to San Francisco
5/27	Visit team pre-Hawaii meeting in San Francisco (finalize plans)
5/28 - 6/3	Hawaiian Island site visits by teams
6/4	Task force travel to San Francisco
6/5	Task force and visit teams post-Hawaii meeting in San Francisco (Review findings, conclusions, recommendations)
6/10	Report drafted and circulated for necessary concurrences
7/10	Concurrences and approvals by CMD and Administrator
7/12	Determine dissemination of Task Force Report (CMD and Administrator)

AMVETS

National Headquarters
4647 Forbes Boulevard, Lanham, Maryland 20706
(301) 459-9600

James G. Bourie
NATIONAL SERVICE DIRECTOR

April 30, 1987

The Honorable Alan S. Cranston
Chairman
Committee on Veterans' Affairs
SR-414 Russell Senate Office Building
United States Senate
Washington, DC 20510-6375

Dear ~~Chairman Cranston~~ Alan:

First, our deep appreciation to you and the members of the Veterans' Affairs Committee for your deep concern and active interest in veteran employment and training programs and services. You have the full support and cooperation of AMVETS.

As regard your follow-up questions on S999, we are pleased to offer the following responses:

1. AMVETS has no official resolution on the matter of residency requirements for SDVETS. However, this issue has long plagued the VETS in attracting and retaining qualified SDVETS. We are aware that there exists an imbalance between those states who have ASDVETS and those which do not, coupled with the provision that qualified candidates cannot cross into different states. By choosing only residents of a particular state, qualified ASDVETS are denied advancement opportunities.
2. In its prepared remarks AMVETS favored a VJTP set-aside for administrative matters for whatever reason(s); training of DVOPs, to increase the VA's VBC's--we thus would be supportive of an administrative set-aside amendment.
3. Also in our remarks AMVETS favored S918 and we now continue to do so.

Should there be any further questions, please feel free to contact me.

Sincerely,

James G. Bourie
National Service Director

JGB:pjf

BLINDED VETERANS ASSOCIATION
1726 M STREET, NORTHWEST, SUITE 800 • WASHINGTON, D.C. 20036 (202) 223-3066

RESPONSES TO QUESTIONS
SUBMITTED BY
SENATOR ALAN CRANSTON
REGARDING S.999 AND S.918

1. The BVA supports the elimination of, or at least, a change in the residency requirement. One change that might be acceptable to all parties would be to require a State Director to first be an Assistant State Director, for at least a period of two years, in some state.

2. No funds should be set aside to (1) provide for the training of DVOPs to perform certain counseling functions for veterans certified for, or participating in VJTA or, to (2) increase the VAs professional counseling services to veterans certified for, or participating in, VJTA. The funds allocated for on the job training should be utilized in that manner. Setting aside even a small amount for training DVOPs as counselors and/or increasing the VAs professional counseling services could allow DOL, the SESAs, and the VA to avoid funding the counseling program.

3. The BVA supports passage of S.918.

CHARTERED BY THE CONGRESS OF THE UNITED STATES

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

May 12, 1987

Honorable Alan Cranston, Chairman
Senate Veterans Affairs Committee
414 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Cranston:

This is in response to your request for our views on S. 918.

Chairman Cranston, the DAV fully recognizes this legislation was introduced at the request of the Administration and, therefore, does not necessarily represent your views. Quite frankly, the DAV has some concerns about the so-called "improvements" contained in this measure.

As introduced, S. 918 proposes, among other things, to make certain improvements in the VA's educational assistance programs. Title I, Section 101 of the measure proposes to amend Title 38, U. S. Code to provide for a two week period, after initial entry on active duty, during which an individual has to exercise their right to decline participation in the New GI Bill. Mr. Chairman, the DAV has no official position on this proposed change.

Section 102 of Title I proposes to eliminate, from Section 1508 and 1780 of Title 38, U. S. Code, the Administrator's authority to make advance payments of subsistence allowances under Chapter 31. As you are well aware, Congress established the advance payment program in recognition of the extra financial burdens placed upon veterans beginning a program of education or training.

The Administration espouses the view that Chapter 31 participants -- all of which are service-connected disabled veterans -- do not need the extra assistance, as all fees associated with their entry into training are paid by the VA; authority already exists in Section 1512, Title 38, U. S. Code to provide a revolving fund loan.

Mr Chairman, the DAV believes it is presumptuous of the Administration to say that service-connected disabled veterans do not need assistance when initially entering a program of training the same as other non-disabled veterans.

Furthermore, it is significant to point out that Section 1780 of Title 38, U. S. Code, provides that the Administrator shall make advance payments of educational or subsistence allowances while Section 1512 of Title 38, U. S. Code provides that the Administrator may make revolving fund loans to veterans participating in a course of vocational rehabilitation under Chapter 31.

Mr. Chairman, in as much as the proposed revision of Section 1780, Title 38, U. S. Code may impact adversely upon service-connected disabled veterans entering a program of training under Chapter 31 we are opposed to its enactment.

Section 103 of the measure proposes to eliminate a provision in Section 1685 of Title 38, U. S. Code which requires the VA to make an advanced payment of 40 percent of the total work study allowance to a veteran-student. Mr. Chairman, we see no valid reason or justification to discontinue this practice as veteran-students, for the most part, have limited finances and resources.

Section 104 proposes to change Section 1788(c), Title 38, U. S. Code to consider two "50-minute periods" of laboratory instruction as a standard class session. As we understand, this change is necessary to extend full credit for lab sessions, since most educational institutions now use 50-minute rather than 60-minute laboratory sessions. The DAV has no objection to this change.

Section 105 of the measure proposes to amend Section 1793 of Title 38, U. S. Code to remove the numerical guidelines for VA compliance surveys -- and allow the VA to conduct such surveys "whenever appropriate and in the best interest of the government." Mr. Chairman, the DAV has not seen any evidence to indicate that the current compliance survey requirements are not working.

Section 106 proposes a technical amendment to amend Title 38, U. S. Code to provide that Chapter 32 complies with Section 3013, the same as required of Chapters 30, 31, 34 and 35. The DAV has no objection to this technical amendment.

Finally, Title II, Section 201 of the measure, proposes to repeal the authority in Title 38 to make educational loans (including accelerated payments) to eligible veterans. Mr. Chairman, the practice of making educational loans or accelerated payments have assisted many veterans in furthering their education, many of whom would not have otherwise been able to do so. For this reason, we must seriously question the wisdom in terminating such a program. Consequently, Sections 202 and Title III, Section 301, in our opinion, are not necessary.

Mr Chairman, this concludes our comments regarding S. 918. We appreciate the opportunity to express our views on this measure.

Sincerely yours,

John F. Heilman

JOHN F. HEILMAN
National Legislative Director

JFH:lrd

PVA

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

May 13, 1987

The Honorable Alan Cranston, Chairman
Senate Committee on Veterans' Affairs
414 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Cranston:

Thank you for allowing PVA to testify at the Senate Committee on Veterans' Affairs April 30 1987 hearing, concerning employment and education legislation. Enclosed for the hearing record are answers to your questions pertaining to the hearing.

Question 1. In Ron Drach's testimony, he states that the requirement limiting the appointment of a state director of veterans' employment and training to those who have been residents of the State for at least 2 years is too rigorous. He recommends that the residency requirement for State Directors be allowed to be waived so that Assistant State Directors could be considered for State Director vacancies in states in which they do not reside.

Answer 1. PVA would agree with the DAV and Mr. Drach's assessment.

Question 2. What would be each of your positions on adding to the legislation a set-aside of a very small percentage -- say 1 or 2 percent -- of V.J.T.A. funds to be used (1) To provide for the training of D-VOPs to perform certain counseling functions for veterans certified for, or participating in, V.J.T.A. and, (2) to increase the V.A.S. professional counseling services to veterans certified for, or participating in, V.J.T.A.

Answer 2. PVA agrees, it is needed.

Question 3. In the chairman's invitation letter to you he asked for your comments on S. 918, the proposed "Veterans' Educational Assistance Improvements Act of 1987" which he has introduced at the request of the Administration. If you have not provided your views on this bill in your prepared statement or oral testimony, would you please submit them for the record?

Answer 3. Our concerns to S. 918 were expressed in our testimony on page 3, and, as long as veterans under Chapter 31 are eligible and can receive advances from the revolving fund, which adequately addresses our concerns brought out in our testimony, we have no opposition to S. 918.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300
Chartered by the Congress of the United States

The Honorable Alan Cranston
Page Two
May 13, 1987

Again, thank you for your concern and for holding the April hearing. Also, thank you for allowing PVA the opportunity to testify, and I hope our input has been helpful. Please don't hesitate to contact us if you have any questions regarding our answers.

Sincerely yours,

Bob Moran

Bob Moran
Associate Legislative Director

BM/ef

cc: The Honorable Frank H. Murkowski

The American Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

May 1, 1987

Honorable Alan Cranston, Chairman
Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Attached are The American Legion's responses to the questions that you recently raised concerning veterans employment matters. Should you have any further questions, please contact either myself or Mr. Phil Riggin, the Legion's Director of Legislation.

As always, we look forward to working with you and your staff on the important issues that lie before us.

With best personal regards, I am

Sincerely,

DENNIS K. RHOADES
Director for Economics

Attachment

RESPONSES TO FOLLOW-UP QUESTIONS POSED BY THE SENATE COMMITTEE ON VETERANS AFFAIRS RELATIVE TO S.999 AND S.918

1. Q: In Ron Drach's testimony, he states that the requirement limiting the appointment of a State Director of Veterans' Employment and Training to those who have been residents of the state for at least two years is too rigorous. He recommends that the residency requirement for State Directors be allowed to be waived so that Assistant State Directors could be considered for State Director vacancies in states in which they do not reside. What are each of your views on that recommendation?

1. A: The American Legion has not favored in the past any changes to the residency requirements for State and Assistant State Directors for Veterans' Employment and Training. We support the appointment of veterans advocates who are familiar with the state and the political processes which are becoming increasingly important to assure that veterans in that state receive the preferential services to which they are entitled. In addition, we would need to have absolute confidence that any such change would preserve the integrity of these key positions by prohibiting their use as rewards for otherwise inexperienced national political appointees.

2. Q: What would be each of your positions on adding to the legislation a set-aside of a very small percentage -- say one or two percent -- of V.J.T.A. funds to be used (1) to provide for the training of DVOPS to perform certain counseling functions for veterans certified for, or participating in, V.J.T.A. and, (2) to increase the V.A.S. professional counseling services to veterans certified for, or participating in, V.J.T.A.?

2. A: The American Legion strongly favors the provision of supportive services to veterans eligible for, or participating in V.J.T.A., and recognizes that without additional resources, the effectiveness of such services may be limited. As to the disposition of such additional resources, we see considerable merit in the application of funds to provide training for LVERs and DVOPs in certain counseling functions. We believe, on the other hand, that the size of the proposed set aside ($600,000 - $1,200,000) is insufficient for increasing the VA's professional counseling services. Based on an average cost of $48,000 (including non-personnel services) for a counseling psychologist, dedication of the entire set aside would only generate 12-26 positions nationwide.

3. Q: In the Chairman's invitation letter to you he asked for your comments on S. 918, the proposed "Veteran's Educational Assistance Improvements Act of 1987" which he has introduced at the request of the Administration. If you have not provided your views on this bill in your prepared statement or oral testimony, would you please submit them for the record?

3. A: Section 101 of this bill would amend section 1411 (c)(1) to allow an election not to participate in the basic educational assistance entitlement under Chapter 30 to be made within 14 days of entrance onto active duty, rather than at the time the individual offers a period of time for the enlistee to consider this education program and its potential benefits prior to the time that a final decision is required.

Section 102 would amend Chapter 31 so as to delete the provision for advance payment of subsistence allowance for the vocational rehabilitation program. Advance payment of education benefits was originally granted to those under Chapter 34 in the mid 1970s. It was extended to Chapter 31 in 1980. Although the Veterans Administration pays the training costs in a program of vocational rehabilitation, there are additional expenses involved with beginning such a program. These involve travel, lost wages and other issues which may create a need for the advance payment. Therefore, The American Legion would not support this proposal.

Section 103 of the bill would delete the advance payment of a portion of the VA workstudy allowance. As we understand it the reasoning for this legislation is that overpayments are a major problem in this program. The overpayments apparently stem from large numbers of veterans dropping out of school. Administrative offsets are not feasible and the payments are relatively small. It would appear to us that there exists a lack of administrative control to prevent such overpayments. The Administration's solution is to discontinue the benefit rather than to correct the situation. We do not support this proposal.

Section 104 of the measure would amend the definition of the term "standard classroom session" pertaining to laboratory instruction to reflect current institutional practices of having lab instruction courses of two 50 minute periods rather than a standard two hour lab. This is a technical amendment to which we would not offer objection.

Section 105 would delete the current requirement of annual compliance surveys of institutions offering approved courses in which 300 or more veterans are enrolled or which offer NCD courses. Surveys would be conducted "whenever appropriate and in the best interests of the Government". The reason behind this proposal is that it would reportedly permit a more effective use of VA personnel and still maintain active and effective enforcement of the law and regulations.

It would appear to us that these surveys, completed on a regular basis, are an essential means of ensuring the compliance of schools with the law and regulations. In addition, regularly conducted surveys should be a significant factor in reducing the overpayment problem. Therefore, we would not support this provision.

It would appear to us that these surveys, completed on a regular basis, are an essential means of ensuring the compliance of schools with the law and regulations. In addition, regularly conducted surveys should be a significant factor in reducing the overpayment problem. Therefore, we would not support this provision.

Section 106 would amend section 3013 of title 38, to require that awards under Chapter 32 (VEAP) correspond to the extent feasible with the effective dates relating to awards under the other education programs included in this title. This is a technical amendment to which we would have no objection.

Section 201 of the bill would repeal the authority that permits the Veterans Administration to make education loans where there is unused entitlement remaining at the expiration of a veteran's delimiting period, provided he or she was pursuing a program of education on a full-time basis at the time. This has been attempted several times in the past. Although, an earlier cost-savings measure, the Omnibus Budget Reconciliation Act of 1981, limited the number of individuals eligible for VA education loans, those who retain eligibility and who depend on these loans could be forced to discontinue their program of education or training. Thus, The American Legion opposes this initiative as we have previously.

This section would also amend sections 1682A and 1738 which authorize eligible veterans and eligible persons, respectively, to receive education loans in the form of accelerated payments of educational assistance allowances. Accelerated payment under these sections was made contingent upon establishment before November 24, 1982 of programs by States to pay the VA amounts which would match the accelerated payments authorized by VA. Since no States participated in this program, and the lifetime of the program has expired, we would not object to the repeal of these sections.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 1 1987

Honorable Alan Cranston
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed please find the Agency's response to the question which you forwarded for the April 30, 1987, hearing by the Senate Veterans' Affairs Committee. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

Senator Cranston

Question: Mr. Vogel, what would your views be on adding a legislative requirement that VA investigate VJTA employers with "high" drop-out rates and deny them future certification unless corrective action is taken to reduce their drop-out rates?

Answer: As I indicated in my testimony, we do not favor an extension of the VJTA program. In the event that the program is extended, we could not endorse such a legislative requirement. Above all, such investigations would have a chilling effect on employer participation. It is one thing to investigate for illegalities, but it is quite another thing to investigate for lack of success.

Also, there are a number of reasons for high drop-out rates. We know that the overall drop-out rate is 60%. However, this figure has to be analyzed. Upon closer scrutiny, we find that, of the 60%, 25% left for a better job; another 25% left for job dissatisfaction; 40% were laid off or fired and the remaining 10% left for personal reasons, such as bad health. Therefore, it would not be fair to operate on the assumption that the high drop-out rate is entirely attributable to employers.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

May 1, 1987

The Honorable Alan Cranston, Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Chairman Cranston:

Please find enclosed the Veterans of Foreign Wars response to questions submitted by you with respect to testimony given during the recent Senate Veterans' Affairs Committee hearing on April 30, 1987.

With best wishes and kind regards, I am

Sincerely yours,

GORDON R. THORSON, Special Assistant
National Legislative Service

GRT/daa
Enclosure

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 - 5799 ● AREA CODE 202-543-2239

QUESTION #1. In Ron Drach's testimony, he states that the requirement limiting the appointment of a State Director of Veterans' Employment and Training to those who have been residents of the state for at least 2 years is too rigorous. He recommends that the residency requirement for State Directors be allowed to be waived so that Assistant State Directors could be considered for State Director vacancies in states in which they do not reside. What are each of your views on that recommendation?

RESPONSE #1. The Veterans of Foreign Wars does not have a resolution giving us a National mandate to address this issue, therefore we cannot support this proposal.

QUESTION #2. What would be each of your positions on adding to the legislation a set-aside of a very small percentage — say 1 or 2 precent — of V.J.T.A. funds to be used (1) to provide for the training of DVOP's to perform certain counseling functions for veterans certified for, or participating in, V.J.T.A. and, (2) to increase the V.A.S. professional counseling services to veterans certified for, or participating in, V.J.T.A.

RESPONSE #2. The Veterans of Foreign Wars wholeheartedly supports the National Veterans Training Institute, and encourages that this facility be established as a national training resource. We visualize unlimited potential for this training program, and recommend funding for NVTI be established as a separate line item within the Assistant Secretary for Veterans' Employment and Training's annual budget.

Section 2002, 38 USC, charges the Assistant Secretary for Veterans' Employment with providing maximum employment and training opportunities giving priority to the needs of disabled veterans and veterans of the Vietnam-era. This could be accomplished through proper utilization of existing programs, coordination and merger of programs, and implementation of new programs.

Large sums of money have been obligated within Department of Labor programs, such as the Job Training Partnership Act, but have not been utilized for their intended purpose. We submit that the Secretary of Labor, under the guidelines of Section 2002, 38 USC could reobligate funds to enhance the training of the veterans' employment and training service providers. These funds could be further used to conduct outreach awareness and the administering of VJTA programs.

QUESTION #3. In the Chairman's invitation letter to you he asked for your comments on S. 918, the proposed "Veterans' Educational Assistance Improvements Act of 1987" which he has introduced at the request of the administration. If you have not provided your views on this bill in your prepared statement or oral testimony, would you please submit them for the record?

RESPONSE #3. During the VFW oral and written testimony we commented and stated our position on S. 918. We oppose most of the provisions contained in S. 918.

Vietnam Veterans of America, Inc.
2001 S St., NW
Suite 700
Washington, DC 20009-1125

(202) 332-2700

May 4, 1987

Honorable Alan Cranston
Chairman
Committee on Veterans Affairs
SR-414 Russell Senate Office Bldg.
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

On behalf of Vietnam Veterans of America (VVA), I wish to thank you for allowing us to present our views on issues affecting veterans employment and training programs on Thursday, April 30, 1987. Enclosed please find written responses to each of the three questions to which you requested early reply.

VVA also wishes to again to both congratulate and thank you for your strong leadership in moving to improve and extend the Veterans Job Training Act and to strenghten Chapter 41 of Title 38, USC. I hope that our suggestions to you, particularly in regard to participation of veterans in Department of Labor funded training programs, will prove to be of some use to you in your deliberation.

Sincerely,

Richard Weidman

Richard Weidman
Director of Government
Relations

Enclosure

★ A not-for-profit national veterans' service organization ★

Answers to Questions
from Hearing of April 30, 1987

1. On page seven of our statement, Vietnam Veterans of America urges the Committee to either eliminate the residency requirement altogether or to modify it as to allow Assistant State Directors from other states to apply for vacant State Director positions in states in which they do not reside. Twenty of the 52 states and jurisdictions that have State Directors have no Assistant State Directors. On the other hand, there are eighty five Assistant State Directors in the other thirty two states, some states with as many as ten ASDVETS. In short, there is extremely limited opportunity for advancement for most of these people, causing some of the best qualified individuals to leave the Veterams Employment and Training Service. VVA is very much in favor of modifying the residency requirement to allow ASDVETS from other states to apply.

2. VVA would not be in favor of a "set-aside" of VJTA to be used for training DVOPS or paying the VA to counsel VJTA participants. VVA strongly endorses the provision that would legislatively mandate the National Veterans Employment and Training Service Institute (NVETSI). Additional funding for training DVOPS and LVERS should be incuded in appropriations for the NVETSI. As to the Veterans Administration's Vocational Rehabilitation and Education Service being paid for counseling VJTA participants it is VVA's position that this is not the best manner to meet the central problem of there not being enough resources within VR&E. The solution here is fairly straigthforward in that the funds and FTEE devoted to vocational counseling in the FY 1988 budget be increased.

   Lastly in this regard, part of the problem is lack of various types of counseling being available in a timely manner to VJTA or to VR&E participants is a seeming lack of systematic cooperation, coordination, cross-training of personnel, and regular systematic contact between VA personnel and VETS funded personnel at the service delivery level. The current VA/DoL "working agreement" is in need of revision and monitoring of implementation.

3. Vietnam Veterans of America cannot support S. 918, the Administration's proposed "Veterans' Educational Assistance Improvements Act of 1987." In regard to specific areas of S. 918, Section 102 and Section 103 of Title I of the Act would eliminate advance payments for Chapter 31 subsistence allowances and the VA workstudy program. What seems to be in order is better quality control and tighter administrative control of this program to reduce any potential alleged abuse. VVA takes a similar stance toward Section 201 and 202 of Title II which would eradicate even any mention of the Education Loan Program from Title 38.

VVA believes that if the VA needs additional statutory authority in order to properly administer this program then they should request such authority, rather than seeking to eliminate the program altogether. If additional monitoring is needed to better implement this program, VVA is puzzled by Section 105 of Title I, which seems to call for less supervision.

While there may need to be some changes in the time frame when new recruits can "opt in" or "opt out" of the "New GI Bill" (See Section 101 of Title I of the Act), this proposed change does not seem to be material to any concerns that VVA has in this regard based on direct contact with new recruits.

Vietnam Veterans of America does not support S. 918, although VVA does believe that some changes, both administrative and statutory may be needed in regard to both the loan program and the "New GI Bill."

WRITTEN QUESTIONS FROM SENATOR THURMOND TO DR. DAVID AND THE RESPONSES

1. WHAT IS THE COURSE OF FUNDING FOR LOCAL VETERANS' EMPLOYMENT REPRESENTATIVES AND DISABLED VETERANS' OUTREACH PROGRAM PARTICIPANTS?

The basis for funding for the administration of the Employment Security System is the Employment Security Administrative Account (ESAA). The funds collected under this account are used for a variety of administrative activities, including the veterans' representatives and specialists noted in your question. The ESAA is an account funded in total through dedicated tax dollars. Employers are taxed specifically for these Employment Security services, and the funds in the account cannot legally be used for any other program. In actual operation, the Employment Security Administrative Account is very similar to Social Security. The ESAA will have a surplus balance exceeding $1.2 billion on July 1, 1987.

2. WHAT IMPACT WOULD AN INCREASE IN LOCAL VETERANS' EMPLOYMENT REPRESENTATIVES HAVE ON THE BUDGET?

With a $1.2 billion surplus in the ESAA, it is evident that the number of local veterans' employment representatives could be increased as needed with little major effect on the fund's balance. The only problem arises if funds for these positions are switched from other existing programs rather than funded through the substantial surplus. Actual dollar impact could not be estimated until the number of representatives plus their state-associated costs (salaries, fringe benefits, travel and salary increases) could be determined. The surplus is being used as "Hostage Funds" to off-set other deficits in the Unified Budget. Dedicated funds should not be a part of the Unified Budget.

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